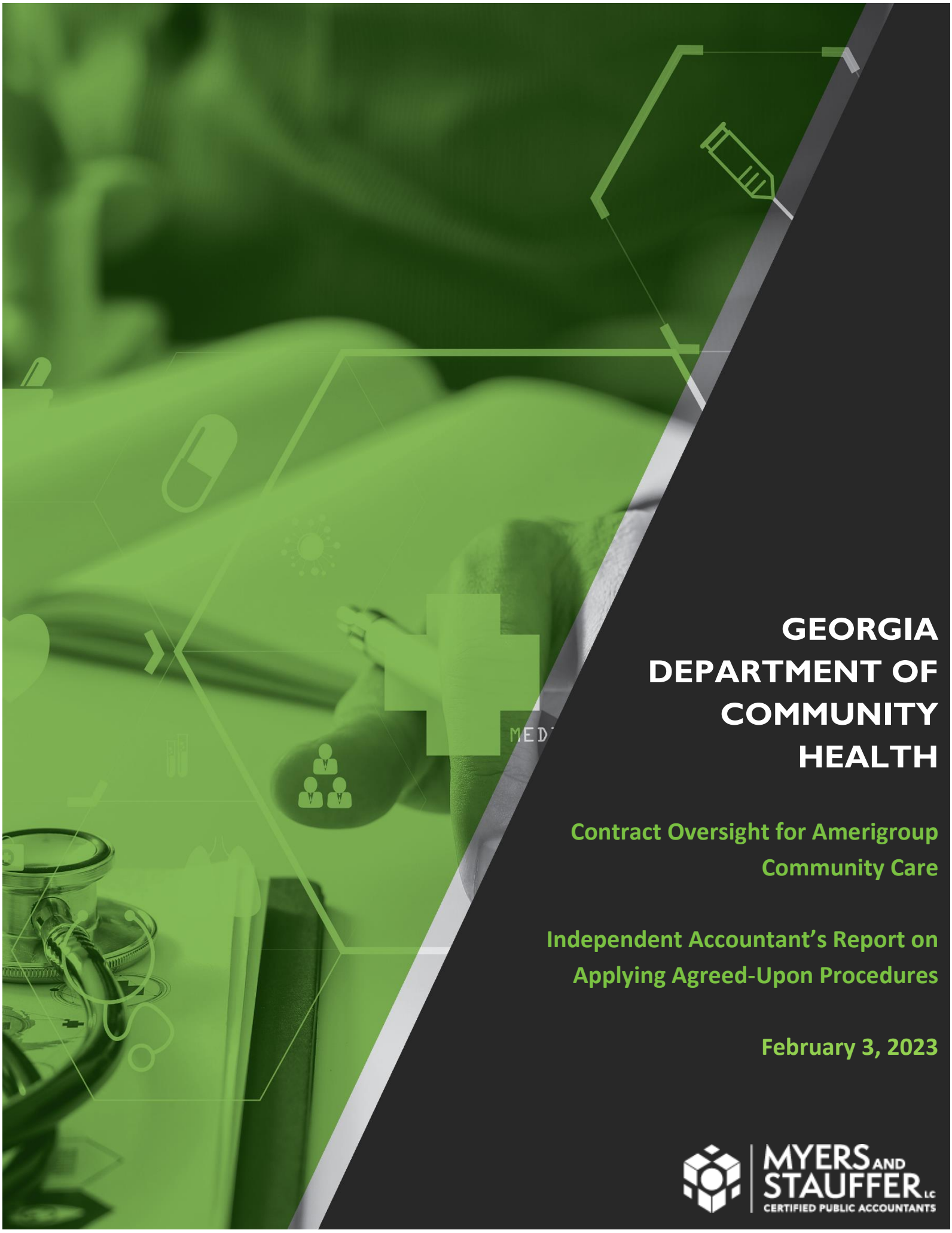


GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Contract Oversight for Amerigroup Community Care

Independent Accountant's Report on Applying Agreed-Upon Procedures

February 3, 2023

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303

We have performed the procedures enumerated in *Appendix B: Agreed-Upon Procedures* on the documentation and information provided by Amerigroup Community Care's (AGP or Amerigroup) for September 16, 2021 through December 6, 2021. We were asked to apply these procedures in order to evaluate Amerigroup's contract compliance, program integrity (PI) oversight, subcontractor oversight, and encounter submissions. Amerigroup's management is responsible for the documentation and information provided, which was submitted to the Georgia Department of Community Health (DCH or the Department) for purposes of compliance with the Department's policies and procedures for encounter submissions.

The Department has agreed to and acknowledged that the procedures performed are appropriate to meet the intended purpose compliance with Medicaid program requirements. This report may not be suitable for any other purpose. The procedures performed may not address all the items of interest to a user of this report and may not meet the needs of all users of this report and, as such, users are responsible for determining whether the procedures performed are appropriate for their purposes.

Our procedures are contained within *Appendix B: Agreed-Upon Procedures* and our findings are contained in the *Findings and Recommendations* section beginning on page 69 of this report.

We were engaged by the Department to perform this agreed-upon procedures engagement and conducted our engagement in accordance with attestation standards established by the American Institute of Certified Public Accountants. We were not engaged to and did not conduct an examination or review engagement, the objective of which would be the expression of an opinion or conclusion, respectively, on Amerigroup's contract compliance, program integrity (PI) oversight, subcontractor oversight, and encounter submissions. Accordingly, we do not express such an opinion or conclusion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

We are required to be independent of the Provider and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements related to our agreed-upon procedures engagement.

This report is intended solely for the information and use of the Department as administrative agent for the Medicaid program, and is not intended to be, and should not be, used by anyone other than this specified party.

Myers and Stauffer LC

Myers and Stauffer LC
Atlanta, Georgia
February 3, 2023

Table of Contents

Project Background

Amerigroup Community Care (AGP) is a subsidiary of Anthem, Inc.[1] (Anthem). Anthem is a leading provider of health insurance and managed health care. AGP is one of three care management organizations (CMOs) providing care management services to Georgia Families, Medicaid, and PeachCare for Kids members, in addition to Planning for Healthy Babies (P4HB) participants under the Georgia Families program. Georgia Families is a risk-based managed care program designed to unite private health plans, health care providers, and patients for the purpose of improving the health status of this population.

Myers and Stauffer has been engaged to assist the Department in its efforts in assessing the policies and procedures of the Georgia Families program. Myers and Stauffer assessments include researching and reporting on specific issues presented to DCH by providers; certain claims paid or denied by the CMOs; and selected Georgia Families policies and procedures. The Department has also engaged Myers and Stauffer to perform agreed upon procedures at each of the CMOs and their subcontractors in order to assess the effectiveness of contractually-mandated monitoring and operational requirements.

As part of this initiative, the Department requested that Myers and Stauffer perform a review of the monitoring activities being performed by AGP to ensure contract compliance by each of its subcontractors; a review of corrective action procedures administered, if any, to AGP's subcontractors as a result of contract non-compliance; and a review of AGP's program integrity procedures.

[1] Anthem, Inc. is now Elevance Health. The change from Anthem, Inc. to Elevance Health is effective June 28, 2022.

Methodology

Pre-Virtual Interviews

On September 24, 2021, we submitted a data and documentation request to AGP prior to initiating the virtual interviews. The materials requested for our analysis were designed to provide us with detailed background information specific to the objectives of this engagement. We reviewed the contracts, policies and procedures, and other documentation related to the engagement's procedures to validate the AGP and its subcontractor's compliance. This review was performed on October 12, 2021 through October 25 2021.

Upon receipt of the data and information requested, we performed a review of the following items:

- *The requirements included in the contract (and amendments) between DCH and AGP.*
- *The requirements included in the contracts between AGP and its subcontractors.*
- *The existing policies and procedures relative to contract compliance, PI, and subcontractor oversight for AGP and the Georgia Families 360° program, and each subcontractor.*
- *The encounter workflows and processes within AGP, within the subcontracted vendors, and between the subcontractors and AGP.*
- *The policies and procedures utilized to ensure timely and accurate reporting of encounters.*

We developed a general template of procedures for the virtual interview activities and identified the specific focal areas based on the results of the preliminary analysis. Utilizing the data and documentation provided, we also performed the following:

- *Identified the staff responsible for the following functional areas: 1) contract compliance; 2) PI; 3) subcontractor oversight; and 4) encounter submissions.*
- *Performed a risk assessment to identify the subcontractors to be included in this engagement.*
- *Obtained DCH approval of the list of subcontractors to be included in this engagement.*
- *Prepared and submitted schedules of AGP and its subcontractor(s) staff to be interviewed.*
- *AGP scheduled all virtual interviews by sending meeting requests to selected participants via Microsoft Teams.*

Virtual Interviews

Virtual interviews of designated AGP and Anthem staff members were conducted by Myers and Stauffer utilizing Microsoft Teams. General and ad-hoc questions were asked of AGP and Anthem staff to ensure

our thorough understanding of the item(s) being discussed. In the same manner, virtual interviews were also conducted with the subcontractors DentaQuest, IngenioRx, CVS/Caremark, One Source Therapy Review (One Source), AIM Specialty Health (AIM Specialty), and Avesis. Myers and Stauffer identified additional AGP staff to interview when further clarification or additional information was needed.

The virtual interviews were conducted on November 1, 2021 through December 6, 2021. *Table 1* outlines the health plan, dates, and the Myers and Stauffer engagement team members.

Table 1: Virtual Interview Schedule and Details

Virtual Interview Schedule and Details		
Health Plan	**Date**	**Myers and Stauffer Engagement Team**
AGP	11/01/2021 – 11/03/2021	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
Anthem	11/08/2021 – 11/10/2021	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
DentaQuest	11/15/2021 – 11/16/2021	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
IngenioRx	11/17/2021 – 11/18/2021	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
CVS/Caremark	11/29/2021 & 12/09/2021	**Myers and Stauffer:** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
One Source	12/07/2021	**Myers and Stauffer** Savombi Fields Stephen Fader Mitchell Keister

Virtual Interview Schedule and Details		
Health Plan	**Date**	**Myers and Stauffer Engagement Team**
		Nickie Turner Hailey Plemons
AIM Specialty	12/08/2021	**Myers and Stauffer** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons
Avesis	12/15/2021 – 12/16/2021	**Myers and Stauffer** Savombi Fields Stephen Fader Mitchell Keister Nickie Turner Hailey Plemons

Myers and Stauffer concluded the virtual interviews by compiling the interview notes, reviewing additional data and documentation received, and preparing any necessary follow-up questions for AGP.

Post-Virtual Interviews

Upon completion of the virtual interviews, Myers and Stauffer identified and documented key findings from the interviews. Myers and Stauffer concluded the interview activities, compiled interview notes, and prepared necessary follow-up questions including requests for additional supporting documentation.

Assumptions and Limitations

1. The existence of a policy or procedure document does not provide assurance that the policy was being adhered to by those to whom the policy was addressed.
2. The findings and recommendations included in this report were limited to the information gathered from interviews and documents provided to Myers and Stauffer by AGP and its subcontractors.
3. Interviews were conducted with members of management and subject matter experts within each organization. We accepted the information that these individuals provided without additional verification.
4. We assumed information received was truthful and correct. Unless information was presented to the contrary, we accepted the information as accurate.
5. The findings and recommendations included in this engagement were limited to the policies and procedures, information system descriptions, data, and other documents provided to Myers and Stauffer by AGP, Anthem, DentaQuest, IngenioRx, CVS/Caremark, One Source, AIM Specialty, and Avesis.
6. We assumed data from AGP's information systems operated as described in the documentation supplied by AGP.
7. We assumed that claims data and claims payment information received was correct. Unless conflicting information was presented to the contrary, we accepted the claims data and claims payment information as accurate.

Contract Compliance

This section of the report provides an overview of AGP's contract compliance. We performed an assessment of the operational areas of behavioral health services, call center operations (member and provider), internal grievance/appeal system, member services, member data maintenance, monitoring and reporting, pharmacy services, provider data maintenance, provider complaints, provider network, provider services, quality management, third-party liability (TPL) and coordination of benefits (COB), and utilization management (UM). We identified the key contractual requirements, then determined whether AGP's policies and procedures were in compliance with the DCH contract outlined in *Appendix C: Contract Compliance*.

Behavioral Health Services

Overview of Behavioral Health Services

Section 4.5.4.3 of the contract requires AGP to provide medically necessary services to correct and/or improve physical and behavioral health disorders, defects, or conditions identified during an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening or preventive visit. Eligible Medicaid members under 21 years of age, regardless of whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act. These services shall be delivered in the most integrated and person-centered settings possible which can be based in the home, school, or the community. As a part or their coordination efforts, physical health and behavioral health providers are required to send status reports to each other informing them on the member's health status. Behavioral health homes are also contractually required as a part of AGP's network.

AGP's policy outlines an integrated approach to the provision of health care services for their members' physical and behavioral health, as mandated by the contract. The behavioral health policy establishes the guidelines by which AGP will identify members in need of intensive behavioral health care management and care coordination between behavioral health, primary care, and dental services. A robust provider network, behavioral health homes and other community resources are maintained in order to provide behavioral health and/or substance abuse services for members identified to receive those services.

Observations: Behavioral Health Services

- *AGP has seven staff licensed in and dedicated to Georgia.*
- *AGP receives between 100 and 150 authorizations for behavioral health services daily.*
- *AGP behavioral health case managers each have an inventory of between 45 to 60 cases.*

- *According to AGP, transportation seems to be the barrier affecting the most members receiving behavioral health services.*
- *AGP receives between 10 and 15 complex and Psychodynamic Diagnostic Manual (PDM) cases per day, with most of those cases coming from predictive modeling.*
- *At the time of our interviews, AGP had approximate 26 active PDM cases.*
- *A single staff member handles all PDM cases.*

Assessment: Behavioral Health Services

After review of AGP's policies and procedures for the behavioral health program, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.5.4.3, 4.6.11.6, 4.6.11.7, 4.8.9.1.1, 4.8.9.1.2, 4.8.9.1.3, and 4.11.8.9.3. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Call Center Operations

Overview of Call Center Operations

Section 4.3.7.1 of the contract requires AGP to operate a toll-free telephone line to respond to member calls, comments, and questions. Policies and procedures must be developed to address staffing and personnel, operational hours, access and response standards (performance), monitoring of calls, and compliance with contract standards.

AGP policy indicates that the plan operates a call center from 7:00 a.m. to 7:00 p.m. with the exception of certain state of Georgia holidays. Members can receive assistance with topics such as the following:

- *Verifying the member's primary care provider (PCP) and/or assisting the member in selecting the PCP.*
- *Communicating the benefits and responsibilities of the health plan and how to access services.*
- *Providing information designed to enhance member participation in EPSDT and other preventive and therapeutic services.*
- *Emphasizing services provided to children and pregnant women.*
- *Reviewing information about services detailed in the member handbook on the following topics:*
    - *AGP and other benefits, emphasizing the importance of early entry and continuous participation in prenatal care and well-child care.*
    - *Covered services, including periodic and inter-periodic screenings and their related schedules by age.*

- *Procedures for accessing services, including emergent and urgent care services.*
- *Complaint/grievance procedures.*
- *Procedures for changing a provider.*
- *Member rights and responsibilities.*
- *Services addressing the needs of linguistic minorities and the disabled.*
- *Procedures to ensure confidentiality of member records.*
- *Mechanisms to assess and enhance member satisfaction with services, including procedures for voicing complaints and recommending changes in policies and services.*

- *Relaying information on health education services offered concerning pregnancy (prenatal and postpartum care), infant care, growth and development, well-child care (infant and young children), and preventive care for all ages.*
- *Referring a member to outsourced ancillary services for dental, vision, mental health, and substance abuse, when applicable.*
- *Referring members who receive provider bills to appropriate AGP representatives for assistance.*
- *Assisting members and pharmacies with prescription billing issues.*
- *Assisting providers and members with verifying eligibility.*
- *Making physician and hospital directory information available to members and prospective members through print and telephone.*
- *Processing member requests for replacement cards, member handbooks, and provider directories.*
- *Member services calls that cannot be handled by the associate answering the call are transferred to the appropriate AGP department or contracted vendor as necessary.*

Per AGP policy, after normal business hours, members have access to an automated member inquiry line that is available 24 hours a day, seven days a week (24/7). The automated system has the capability of providing information such as operating hours information and instructions on verifying enrollment. In addition, the automated system allows callers to leave a message. The member will receive a call back within 24 hours of leaving the message.

Observations: Call Center Operations

- *Call center performance metrics, according to AGP/Anthem, are currently exceeding the mandated goal measure.*

- *The member call center is staffed with six associates, one lead, and one manager.*
- *AGP requires that calls should be resolved within a 72-hour period.*
- *Between member calls, member call center associates perform administrative duties.*

Assessment: Call Center Operations

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, interviews, and live calls. We identified the following potential issue:

- *During a live member call, the member call center agent was unable to provide assistance to a member who wanted to change CMOs.*

Internal Grievance/Appeal System

Overview of Internal Grievance/Appeal System

Section 4.14.1 of the contract requires AGP to have a grievance and appeal system available to its Medicaid members. The system must include a process for receiving, tracking, resolving, and reporting member grievances and appeals.

AGP policy acknowledges the right of the member or their authorized representative to voice dissatisfaction with administration, operations, or provision of health care services. The Welcome Packet given to newly eligible members provides instructions for requesting grievances via the online member handbook. AGP has member representatives who assist members with initiating grievances and completing necessary forms/documents.

Per AGP policy, a member or their authorized representative can initiate a grievance/appeal orally or in writing. The grievances/appeals are documented, tracked, and monitored in a centralized database by the quality management department. Members receive a written acknowledgement letter within 10 days of receiving the grievance/appeal. The grievance/appeal is investigated and upon completion; a resolution letter is mailed to the member indicating the resolution and the basis for the resolution. The resolution letter also notifies the member of their right to appeal the decision. If a member requires assistance with requesting a grievance/appeal, AGP associates are available to assist the member with that request.

Observations: Internal Grievance/Appeal System

- *AGP members may express any type of dissatisfaction when submitting a grievance.*
- *AGP Georgia receives between 30 and 35 grievances weekly.*
- *The timeframe for completion of grievances is within 90 days from the date it is received in PEGA (system used by AGP to receive, track and process appeals, grievances and State Fair Hearings).*

- *AGP members may express dissatisfaction with an adverse decision when submitting an appeal.*
- *AGP Georgia receives approximately 35 appeals weekly.*
- *The timeframe for completion of appeals is within 30 days from the date it is received in PEGA.*
- *An administrative law hearing may be requested by the member upon exhaustion of the internal appeals processes.*

Assessment: Internal Grievance/Appeal System

Myers and Stauffer determined that AGP's policies and procedures for grievance/appeals were in compliance with the DCH contract.

Member Services

Overview of Member Services

Section 4.3 of the contract requires AGP to ensure its members are aware of the following:

- *Member rights and responsibilities.*
- *The role of PCPs and dental homes.*
- *The role of the family planning providers and PCPs.*
- *How to obtain care.*
- *What to do in an emergency or urgent medical situation (for P4HB participants, information must address what to do in an emergency or urgent medical situation arising from the receipt of demonstration-related services).*
- *How to request a grievance, appeal, or administrative law hearing.*
- *How to report suspected fraud and abuse.*
- *Providers who have been terminated from the AGP network.*

The contract mandates that AGP must utilize all forms of communication to reach and receive responses from the largest number of members. Acceptable forms of communications include, but are not limited to, telephone; hard copy documents via mail; email; social media and texting. The email system must allow members to submit questions and receive responses in a secure manner that protects the confidentiality and PHI of the member. Upon request, the AGP must provide Medicaid materials in the format preferred by the member.

AGP policies and procedures establish Customer Care Representatives as the initial point of contact for members. They are responsible for educating members about their rights and responsibilities. They respond to questions regarding benefit coverage, finding a doctor, obtaining a new identification (ID)

card, requesting transportation, and any other member-related questions. They also respond to requests for member materials and provide them to the member in the member's preferred format.

Observations: Member Services

- *AGP has a 24/7 call center staffed with six customer care representatives, one lead, and one manager.*
- *Calls are transferred to the after-hours line at the end of normal business hours.*
- *AGP utilizes Variant, a software that captures audio and video of the incoming calls.*
- *At the time of the interviews, AGP stated they are exceeding the performance metrics mandated service rates with a 90 percent answer rate, less than one minute hold time, less than 30 seconds to answer, and less than five percent abandonment.*
- *AGP has both English and Spanish-speaking associates; and for members who speak other languages, there is an oral interpreter service available.*
- *After authenticating the member, Compass is used by the representative to document the details and outcome of the incoming member telephone calls.*

Assessment: Member Services

After review of AGP's policies and procedures for member services, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.3.1.1.4, 4.3.1.1.8, and 4.3.6.3. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Member Data Maintenance

Overview of Member Data Maintenance

Section 4.17 of the contract requires AGP to develop, maintain, and update an information management system for the purpose of integrating all of the components required for the delivery of care to its members. The system should be secure and have the capability to store and transmit information; interface with other required systems; and report data as requested by DCH.

This information management system will store member demographic information that includes, but is not limited to name, address, date of birth, gender, and race/ethnicity. Additionally, the information management system will also store member health information that includes, but is not limited to the name and address of the member's PCP, Medicaid ID number, services received, recorded immunizations, and future appointments.

AGP policy indicates that the member data maintenance process begins with AGP receiving a daily member enrollment file (834). The 834 file is downloaded utilizing a secured file transfer protocol. The 834 file is then loaded into SQL using *Informatica* to subsequently load into *FACETS*; the system used by AGP to adjudicate member claims. An automatic reconciliation occurs between the information in the 834 file and the State's membership data file. Any discrepancies found in the member enrollment data are resolved within *FACETS.* AGP receives files seven days per week, and on a monthly basis, they receive an audit file containing full membership.

Observations: Member Data Maintenance

- *AGP retains 834 files for 11 years.*
- *AGP identifies the 834 data for each market by a unique group ID number.*
- *Every process utilized to load 834 data into the backend database is automated.*

Assessment: Member Data Maintenance

After review of AGP's policies and procedures for member services, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.17.2.3.1, 4.17.2.3.2, 4.17.2.3.3, 4.17.2.3.4, 4.17.2.4, 4.17.2.4.1, 4.17.2.5, 4.17.2.6, and 4.17.2.8. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We identified the following potential issue:

- *Myers and Stauffer found that AGP does not send an outbound member file to DCH detailing the updates performed as a result of their internal member file review.*

Monitoring and Reporting

Overview of Monitoring and Reporting

Section 4.18.1 of the contract requires AGP to prepare and submit ongoing, dashboard, and ad-hoc reports. The reporting assists DCH with monitoring program performance and analysis. AGP is responsible for collecting, validating, and reporting required program data to DCH in an accurate and timely manner. Reporting should be compliant with the reporting requirements established by the contract and using the formats, including electronic formats, instructions, and timetables specified by DCH.

AGP policy acknowledges the requirement to support DCH in its program monitoring and reporting efforts for overall program performance and trending analysis. In response to this requirement, AGP produces ongoing, dashboard, and ad-hoc reporting for the activities mandated in the contract. AGPs

Regulatory Reporting Center of Expertise (COE) develops and maintains a regulatory reporting database that captures comprehensive documentation of the contractual and regulatory reporting obligations for each state; however, the regulatory reporting database does not capture ad-hoc reporting. The COE also monitors DCH reporting requirements via the contract and the DCH SharePoint site where the DCH Schedule of Reports and DCH-approved report specifications and templates are maintained. AGP follows the timelines outlined in the contract, therefore, report submissions are weekly, monthly, quarterly, bi-annually, and annually.

Observations: Monitoring and Reporting

- *Anthem has a Regulatory Reporting Requirements team which is responsible for all of their reporting.*
- *The reporting database generates monthly reminders.*
- *Dashboard reports can be created and used as a tool to identify the reports that are due.*
- *The business owner of the report is required to submit an internal attestation with the report documenting that it has been validated.*

Assessment: Monitoring and Reporting

After review of AGP's policies and procedures for monitoring and reporting, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.18.2.2, 4.18.3.2, 4.18.4.1, and 4.18.4.2. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Pharmacy Services

Overview of Pharmacy Services

Section 4.6.6 of the contract requires AGP to provide pharmacy services to their members either directly or via a pharmacy benefit manager (PBM). AGP or its PBM may establish a preferred drug list containing therapeutic drug classes sufficient to meet the medical needs of their members. The contract also allows for AGP to create a maximum allowable cost (MAC) schedule to be reviewed no less than every two (2) weeks. The review is to ensure that pricing is appropriate; there are no barriers to access to the medication and that each medication has at least two (2) A-rated generic equivalents. AGP may choose to implement a mail order pharmacy program as an option for its members.

AGP policy outlines the pharmacy benefit coverage required per the Contract. CVS/Caremark serves as the PBM. CVS handles the majority of pharmacy services, while, IngenioRx under contract with CVS/Caremark, is responsible for handling various specialty pharmaceuticals. The policy establishes a MAC schedule to promote the use of generic drugs and aid in cost containment. Brand name drugs are covered in the event there is no generic substitute or the provider requests a brand name out of medical

necessity. Members may receive certain maintenance medications through the mail utilizing home delivery services.

Observations: Pharmacy Services

- *AGP performs a yearly risk-based external audit of CVS/Caremark to ensure compliance with their contractual obligations.*
- *AGP recently added mail order/home delivery as a member benefit under Pharmacy Services.*
- *At the time of the interviews, there were no corrective action plans (CAPs) for CVS/Caremark or IngenioRx in Georgia.*
- *Home delivery provides up to a 60-day supply of eligible non-specialty maintenance medications after at least two 30-day fills at a retail pharmacy in the previous 90 days at the same dose.*
- *Eligible maintenance medications include both brand and generic medications.*
- *Specialty medications, controlled substances, and compounds are not eligible for home delivery.*

Assessment: Pharmacy Services

After review of AGP's policies and procedures for pharmacy services, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.6.6.1.1.1, 4.6.6.1.1.2, 4.6.6.1.1.3, 4.6.6.1.2, 4.6.6.1.3, 4.6.6.2, 4.6.6.2.1, 4.6.6.2.2, and 4.6.6.2.3. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Provider Data Maintenance

Overview of Provider Data Maintenance

Section 4.17 of the contract requires AGP to develop, maintain, and update an information management system for the purpose of integrating all of the components required for the delivery of care to its members. The system should be secure and have the capability to store and transmit information; interface with other required systems; and report data as requested by DCH.

This information management system will store provider information including, but not limited to, provider name; designation as a professional group or facility; provider's address and phone number. Additionally, the provider type including any specialty designations and/or credentials will be stored.

AGP is contracted to utilize an information management system to maintain provider information. Policy indicates that the provider data maintenance process begins with AGP receiving a daily 7400 provider data file from the State. The 7400 file is used to compare against the provider information stored in

FACETS. The 7400 file is loaded and only updates information for existing providers. New providers and their data will not be loaded.

Observations: Provider Data Maintenance

- *AGP loads credentialing daily. Both participating and non-participating providers are loaded.*
- *The quality review of provider data consists of reviewing the data on the 7400 against the data in FACETS.*
- *AGP utilizes the 7400 file as the source of truth as it relates to Medicaid provider data.*
- *New providers are compared against the weekly Centralized Verification Organization (CVO) file.*
- *Providers completely credentialed by the State can have a contract executed with AGP and subsequently, the provider may be added to the network.*
- *Single case agreements are used by AGP as a means to address potential deficiencies in their provider network.*

Assessment: Provider Data Maintenance

After review of AGP's policies and procedures for pharmacy services, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.17.2.3.1, 4.17.2.3.2, 4.17.2.3.3, 4.17.2.3.4, 4.17.2.4, 4.17.2.4.1, 4.17.2.5, 4.17.2.6, and 4.17.2.8. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We identified the following potential issue:

- *Virtual interview responses indicate that the contracting team is not fully reviewing and utilizing the network adequacy deficiency reports.*

Provider Complaints

Overview of Provider Complaints

Section 4.9.7 of the contract requires AGP to create a provider complaint system. The provider complaint system allows providers to dispute AGP policies, procedures, or any other aspect of their administrative functions. The policies and procedures for the complaint system should be included in the provider handbook and available for all network providers. Instructions for filing a provider complaint should also be included in the provider handbook.

AGP, per policy, maintains a provider complaint system where both participating and non-participating providers can have their complaints or inquiries heard, evaluated, and addressed. Providers are required

to submit complaints, including any supporting documentation, in writing by mail to the address specified in the provider handbook. Policy requires that an acknowledgment letter is sent to the provider within 10 business days of receiving the complaint(s). Each complaint is thoroughly investigated, and a resolution letter is sent to the provider within 30 calendar days from receipt of the complaint.

Observations: Provider Complaints

- *AGP advises providers who call in with complaints to utilize the complaint system by submitting their complaint in writing.*
- *Claim or UM-related provider complaints are input into the payment error rate measurement (PERM) system for tracking and resolution.*
- *Claims-related complaints are resolved in the provider resolution system.*
- *Provider complaints submitted to AGP from DCH are logged and tracked separately.*
- *If the investigation results in an adverse decision, the resolution letter will reference additional complaint review steps that may be taken.*

Assessment: Provider Complaints

After review of AGP's policies and procedures for pharmacy services, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.9.7.3, 4.9.7.4.2, 4.9.7.4.3, 4.9.7.4.4, 4.9.7.4.5, 4.9.7.4.6, 4.9.7.4.7, 4.9.7.4.8, 4.9.7.4.9, 4.9.7.4.10, 4.9.7.4.11, 4.9.7.6, and 4.9.7.7. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Provider Network

Overview of Provider Network

Section 4.8.1 of the contract requires AGP to develop and maintain a network of providers and facilities that is robust enough to deliver covered Medicaid services to its members. The network must ensure adequate coverage exists for both rural and urban areas, while making telemedicine an option when appropriate for the member's health care needs. The network should consist of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, border providers, and other health care providers. The network providers must be appropriately credentialed by DCH or its agent, maintain current license(s), and have appropriate locations to provide covered Medicaid services.

AGP, per policy, develops and maintains an adequate network of providers and facilities to deliver services to their members. The network contains hospitals, physicians, pharmacies, physical therapists, occupational therapists, speech therapists, border providers, and other health care providers. The

network ensures adequate services to AGP's members residing in rural areas. The primary way AGP ensures an adequate provider network is by recruiting. The 7400 files and CVO files are used to identify providers who are enrolled as Medicaid providers with DCH and it is coupled with network adequacy and geo-access reports to identify providers to recruit.

Observations: Provider Network

- *In an effort to attract new providers to the network, AGP makes cold calls to new providers introducing and inviting them to the network.*
- *In an attempt to maintain an adequate network, providers interested in single case agreements are encouraged to enroll as network providers.*
- *Single case agreements are negotiated with providers that choose to not sign a contract for network participation in order to address network gaps.*
- *Geo-access reporting is reviewed on a quarterly basis.*

Assessment: Provider Network

After review of AGP's policies and procedures for pharmacy services, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.8.1.4 and 4.8.1.5. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Provider Services

Overview of Provider Services

Section 4.9.1 of the contract requires AGP to provide information about Georgia Families to all providers in order to operate in full compliance with the contract and all applicable federal and state regulations. AGP is responsible for monitoring provider knowledge and understanding of provider requirements, and taking corrective actions to ensure compliance with the requirements. The contract requires AGP to provide all providers with a copy of the provider handbook and to provide a hard copy upon provider request. For the providers, the provider handbook serves as a source of information regarding covered services, policies and procedures, statutes, regulations, telephone access, and special requirements to help ensure all contract requirements are being met.

AGP, per policy, maintains a provider services department that utilizes customer care representatives who provide information about Georgia Families to both participating and non-participating providers. A toll-free provider service line is dedicated to provider service calls. Providers can call to get assistance with member information such as benefits and enrollment status. Additionally, providers can obtain information regarding claims and payment, prior authorizations, provider information, the policies and

procedures outlined in the provider manual, complaints and assistance filing, appeals and assistance filing, web portal functionality, and assistance with obtaining forms.

Observations: Provider Services

- *AGP, due to COVID-19, is not performing on-site visits with providers at this time.*
- *Virtual provider visits are being performed utilizing Microsoft Teams.*
- *Customer care representatives are required to perform a minimum of 30 provider visits per month. Provider contacts made via email and telephone are counted towards the 30 visits.*
- *Provider contacts are documented in the PERM system.*

Assessment: Provider Services

After review of AGP's policies and procedures for provider services, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.9.1.3, 4.9.1.4, and 4.9.2.1.27. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Quality Management

Overview of Quality Management

Section 4.12.1 of the contract requires the delivery of quality care to be AGP's primary goal, resulting in improved or maintained health status of its members. This includes the implementation of interventions and designation of adequate resources to support the intervention(s) necessary for members identified by AGP as being at risk of developing serious conditions. AGP will be required to partner with the member, providers, community resources, and other agencies to improve the quality of care provided to its members.

AGP has policies and procedures in place to manage the quality of care provided to its membership, as mandated by the contract. The primary goal of these policies and procedures is to ensure the provision of quality care resulting in the improvement of member health. There will be situations where the member's health status cannot be improved. In these cases, measures must be implemented to prevent further decline and/or deterioration of the member's condition or health. Cost containment and directing members' care are direct results of quality management.

AGP policies and procedures for quality management include strategies for identifying members at risk of developing health conditions and intervening to prevent decline or deterioration of those health conditions. Improving and/or maintaining the member's health condition is a joint effort involving the member, providers, community resources, and other health agencies who all strive for the primary goal of improving member's overall quality of care.

Observations: Quality Management

- *AGP performs audits of provider records on a quarterly and semi-annual basis.*
- *Patient safety audits are performed annually and semi-annually.*
- *Providers must receive 80 percent or above on their audits, otherwise, education is performed and they will be re-audited.*
- *AGP currently has an administrative process improvement project (PIP) in place with DCH. The PIP is on a three-year cycle, and AGP will collaborate with DCH on the topics.*
- *AGP currently has a clinical PIP in place with DCH. The PIP is on a three-year cycle and AGP will collaborate with DCH on the topics.*

Assessment: Quality Management

After review of AGP's policies and procedures for quality management, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.12.1.2, 4.12.2.1, and 4.12.3.6. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Third Party Liability and Coordination of Benefits

Overview of Third Party Liability and Coordination of Benefits

Section 8.4 of the contract requires AGP to make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CMO members. TPL refers to the legal obligation of any other health insurance plan or carrier (e.g., certain individuals, entities, insurers, or programs) to pay all or part of the health care expenses of the member. Additionally, AGP is required to use cost avoidance processes to ensure primary payments from the liable third party are identified. DCH has authorized AGP to identify and cost avoid claims for all managed care members, including those enrolled in PeachCare for Kids.

AGP policy provides guidelines for the COB on claims when the member has health insurance in addition to Medicaid. COB establishes the order in which insurance plans pay claims when a member is covered by more than one plan, while TPL refers to the legal responsibility of insurers to pay all or part of medical claims.

Per AGP policy, the TPL/COB claims are processed utilizing the payment information from the member's primary insurance carrier(s). The process begins with the provider submitting a claim containing COB information or with the primary payor's explanation of benefits. In the event a recovery of funds is due from the other insurance company or a claim(s) should not have been paid, the TPL/COB analysts

perform post-payment adjustments and utilize Health Management Systems (HMS) to recover funds due to AGP.

Observations: Third Party Liability and Coordination of Benefits

- *AGP/Anthem has an automated process to adjust COB/TPL claims for Georgia automatically.*
- *COB/TPL claims are adjusted in FACETS.*
- *AGP receives leads for potential member COB and TPL coverage from HMS and CAQH vendor files.*

Assessment: Third Party Liability and Coordination of Benefits

After review of AGP's policies and procedures for TPL and COB, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 8.4.1.3, 8.4.1.4, 8.4.2.1, 8.4.2.2, 8.4.2.4.1, 8.4.2.4.2, and 8.4.2.5. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Utilization Management

Overview of Utilization Management

Section 4.11.1 of the contract requires AGP to implement effective UM processes and procedures to ensure a high quality, clinically-appropriate, highly-efficient, and cost-effective health care delivery system. AGP is required to provide ongoing evaluation of the cost and quality of medical services provided by providers and to identify potential over and under-utilization of clinical services. Additionally, AGP must apply objective and evidence-based criteria that take the individual member's circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

AGP UM policy outlines the means by which quality and the appropriate use of health care-related services is determined. UM also ensures AGP members are treated in the most appropriate, least restrictive, cost-effective setting based on the severity of the illness and/or the intensity of the services needed in order to result in an improved health status relative to the specific condition. Prior authorizations and pre-certifications are used to manage the utilization of certain Medicaid services, ensure high quality, ensure appropriateness of services, and manage costs.

Observations: Utilization Management

- *AGP has 14 staff responsible for processing prior authorization requests.*
    - *There are 10 clinical staff (nurses).*
    - *There are four non-clinical staff.*

- *AGP providers utilize the Georgia Medicaid Management Information System (MMIS) to enter authorization requests.*
- *There is a three-day turnaround time for completed authorizations.*
- *Expedited authorization requests are usually completed within 24 hours.*
- *A high-dollar review is any authorization request for billable services above $2,000.00.*

Assessment: Utilization Management

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Program Integrity Oversight

This section of the report provides an overview of AGP's PI oversight. We performed an assessment of AGP's policies and procedures for PI oversight. We identified the key contractual requirements, then determined whether AGP's policies and procedures were in compliance with the DCH contract outlined in *Appendix C: Contract Compliance*.

Contract Requirements and Consistency of AGP Policies and Procedures for Program Integrity Oversight

Overview of Program Integrity Oversight and Virtual Interview Observations

Section 4.13.1 of the contract requires AGP to implement and maintain a PI program that includes a mandatory compliance plan designed to safeguard against fraud, waste, and abuse (FWA). The PI program must include policies, procedures, and standards of conduct allowing for the prevention, detection, reporting, and corrective action for suspected and confirmed cases of FWA relating to the administration and delivery of Medicaid services under this contract.

The contract also requires the designation of a compliance officer who is accountable to AGP's senior management and is responsible for ensuring policies to establish effective lines of communication between AGP and DCH staff exist and are being adhered to.

AGP maintains a PI program to address how they detect, report, prevent, and apply corrective action(s) to suspected cases of FWA in the provision of Medicaid services. AGP's PI policies, procedures, and standards of conduct are documented and include corrective action of suspected cases of fraud and abuse as a means to ensure the integrity of the Georgia Families program. As a part of PI policy and procedures, AGP maintains a mandatory compliance program and pharmacy lock-in program as required under the contract. AGP has a compliance officer responsible for ensuring the implementation and ongoing operation of a comprehensive compliance program including the monitoring and oversight of adherence with Medicaid legal, regulatory, and contractual requirements. The role also includes the assessment, identification, and remediation of compliance risks such as FWA of health care services.

Observations: Program Integrity Oversight

- *AGP receives FWA leads from the following:*
    - *Members.*
    - *Internal associates.*
    - *DCH.*

- *Other CMOs.*
- *The Fight Fraud website (www.fighthealthcarefraud.com).*

- *Data mining is an additional means to identify potential FWA cases.*
- *All FWA cases are given a post-payment review.*
- *Open reports are reported to DCH on a quarterly basis.*
- *Recoveries are reported to DCH and tracked in FACTS.*

Assessment: Program Integrity Oversight

After review of AGP's policies and procedures for PI, Myers and Stauffer did not identify policies or standard operating procedures for contract sections 4.13.1.3, 4.13.2.1.13, and 4.13.2.1.14. We recommend that AGP, in accordance with their contract with DCH, create policies and/or policy references to address the contract requirements outlined in these areas.

Fraud, Waste, and Abuse Reporting

AGP is contractually required to submit a quarterly Fraud and Abuse Report to DCH. The contract specified that the reports must contain suspected cases of FWA identified in the administration and delivery of Medicaid services. FWA case reporting is required to include, at a minimum, the:

- *Source of complaint.*
- *Alleged persons or entities involved.*
- *Nature of the complaint.*
- *Approximate dollars involved.*
- *Date of the complaint.*
- *Disciplinary action imposed.*
- *Administrative disposition of the case.*
- *Investigative activities, corrective actions, prevention efforts, and results.*
- *Trending and analysis as it applies to UM, claims management, post-processing review of claims, and provider profiling.*

Myers and Stauffer reviewed four quarterly Fraud and Abuse Reports submitted by AGP for the third quarter of calendar year 2020 through the second quarter of calendar year 2021. These reports comprised 168 FWA cases. We reviewed the history of these cases in terms of the CMO's Special Investigative Unit (SIU) productivity, case mix, case outcomes, completeness, and consistency of reporting.

SIU Productivity

During the study period (July 2020 through June 2021), AGP started with a backlog of 118 FWA cases, opened 50 additional cases, closed 108 cases, and ended with a backlog of 60 FWA cases. The following diagrams trend case activity during the study period. It appears the most dramatic reduction in backlog occurred during February and March 2021. Additionally, there appeared to be an effort at the beginning of the fiscal year (July 2020) to close out old cases, as 13 of the 17 cases closed that month had been open for more than two years. The typical turnaround time (from open to close) for all cases closed during the study period was approximately 13 months. Refer to *Figure 1* and *Figure 2* for a visual depiction of SIU productivity during the study period.

Figure 1: Number of FWA Cases Opened and Closed During Each Month

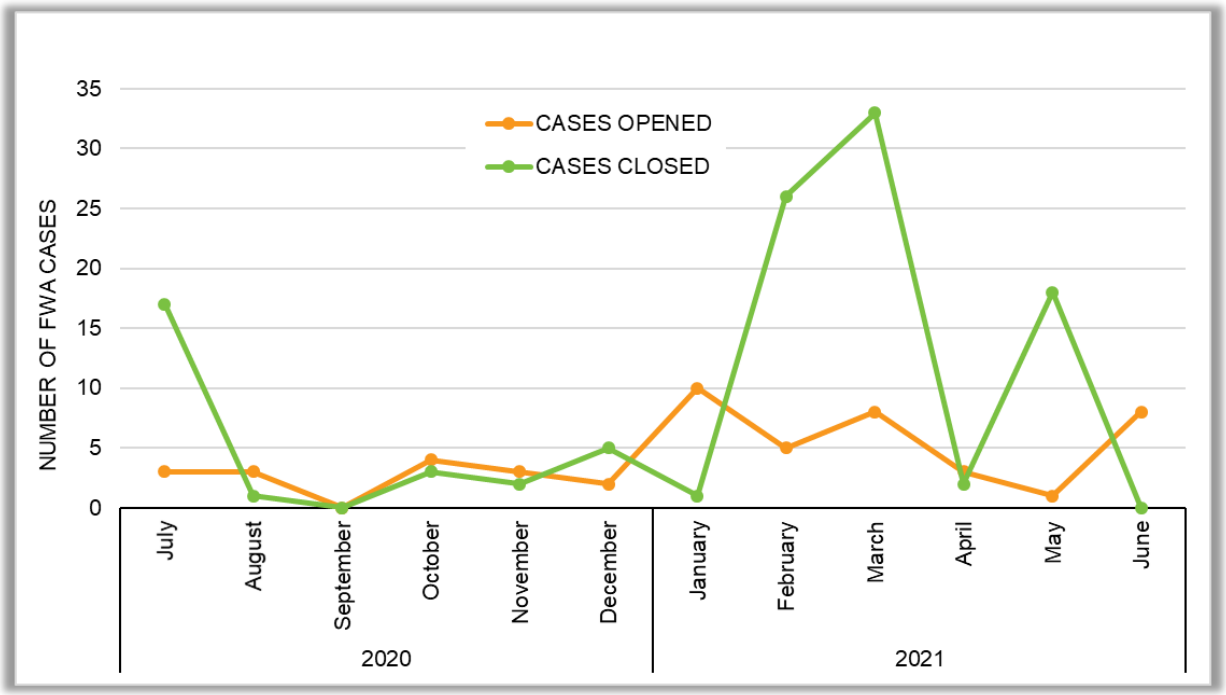
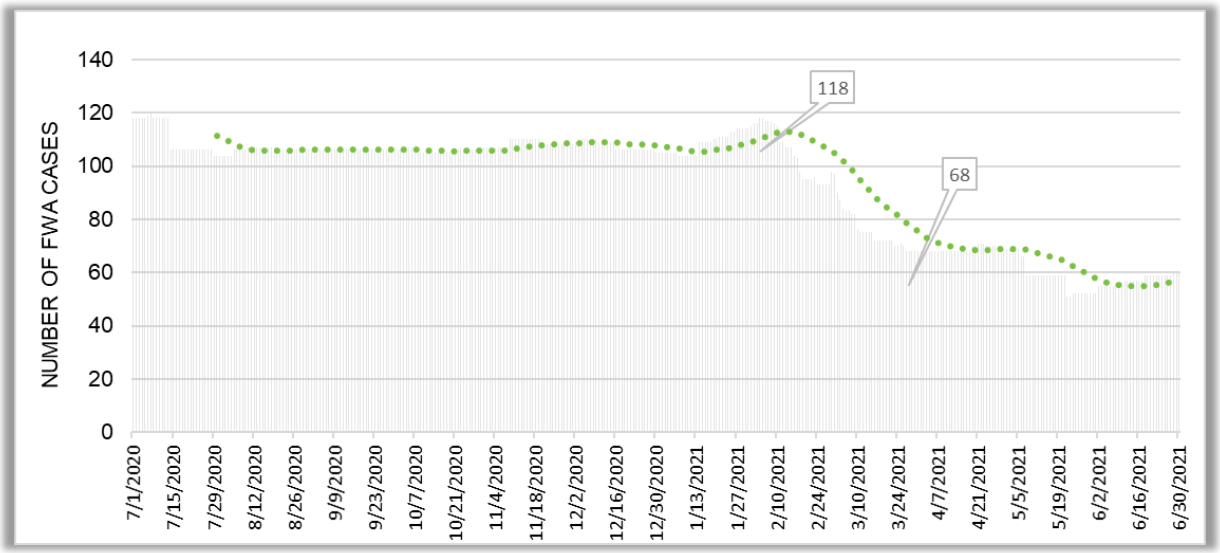


Figure 2: Number of Backlogged FWA Cases by Date



The Impact of COVID-19 on SIU Activities

During the review of the 168 cases' activities and outcomes, we observed 63 (37.5 percent) of cases were closed or suspended, noting a DCH COVID-19 stand down order. Specifically, "*In April 2020, the State of Georgia implemented a full stand-down on all SIU activities, due to the COVID-19 Pandemic. As of January 2021, this stand-down remains in effect.*" This appears to have been associated with the dramatic reduction in SIU case backlog occurring during February and March 2021. In many of the case notes are indications that investigations and disciplinary actions may resume when stand-down orders are lifted. All DCH CMO SIUs may need to carefully review all FWA cases closed during the DCH stand-down orders to assess the need to resume some of these cases.

The following sections include, as appropriate, the impact of the COVID-19 stand-down orders on our observations about FWA case mix and outcomes.

FWA Case Mix

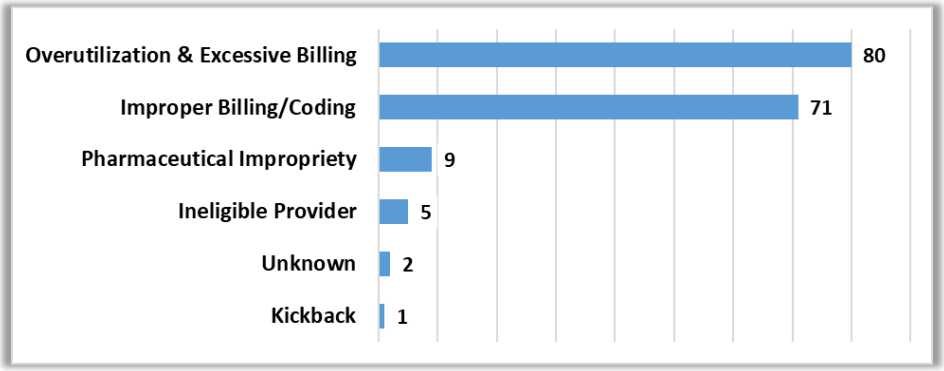
Myers and Stauffer reviewed the FWA case mix for the 168 active cases during the study period in terms of the alleged FWA schemes and the types of providers, individuals, and entities involved. We grouped these cases into seven categories of FWA schemes, based on the nature of the complaint stated in the FWA quarterly reports. From most to least frequent, they were:

1. Overutilization and excessive billing.
2. Inappropriate billing, including upcoding, unbundling, and false billing/diagnosis.

3. Pharmaceutical impropriety, including drug diversion, excessive prescribing patterns, phantom pharmacy, and prescriptions with no oversight.
4. Ineligible provider, which includes unlicensed providers and rendering services outside the scope of practice.
5. Kickback.

No member fraud cases appeared in FWA reports during the study period.

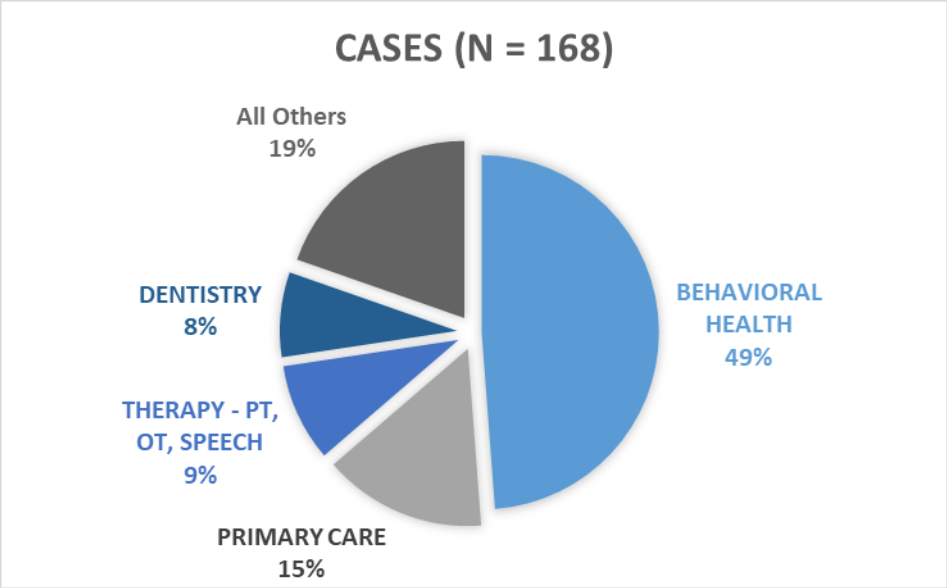
Figure 3: FWA Scheme Categories – Number of Cases



Of the alleged parties in the 168 FWA cases active during the study period, the bulk of the SIU activity appeared to involve behavioral health, primary care, therapy, and dentistry, as shown in

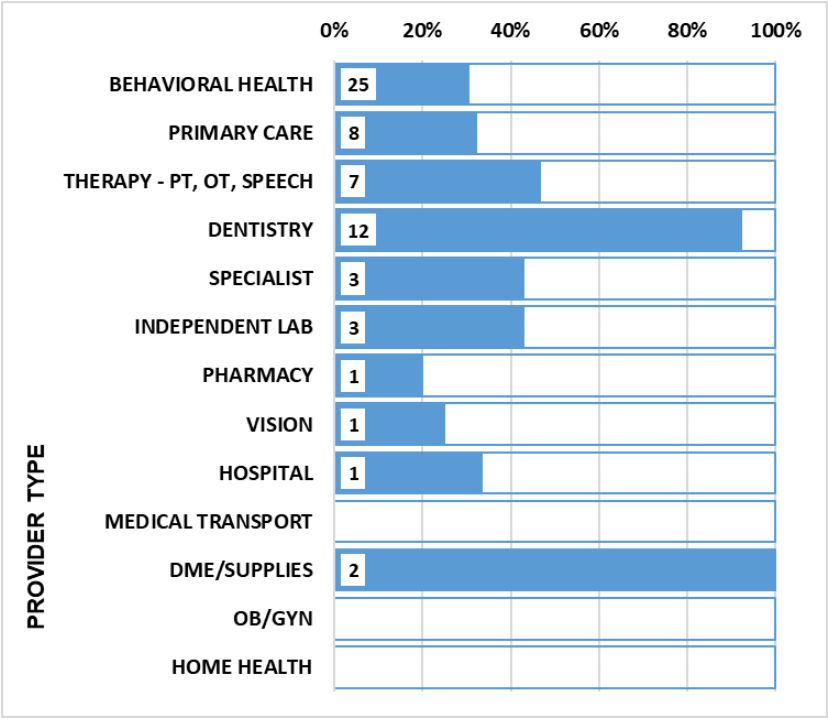
Figure 4.

Figure 4: FWA Cases by Provider Type



The DCH COVID-19 stand-down order appears to be correlated with provider type, suggesting the stand-down order may have been targeted in some respects. As shown in *Figure 5*, nearly all dentistry cases were impacted by the order.

Figure 5: Number and Percentage of FWA Cases Impacted by the DCH COVID Stand-Down Order

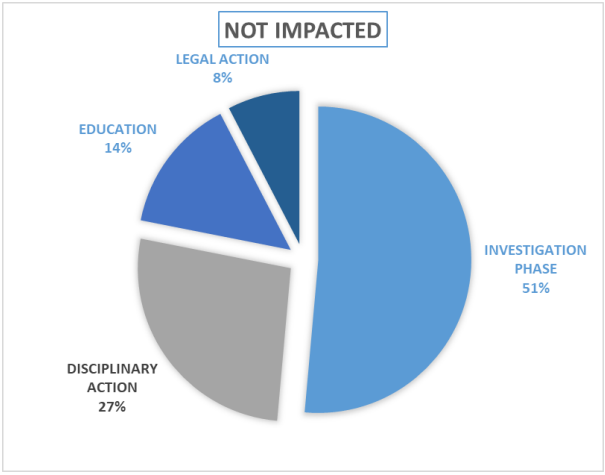


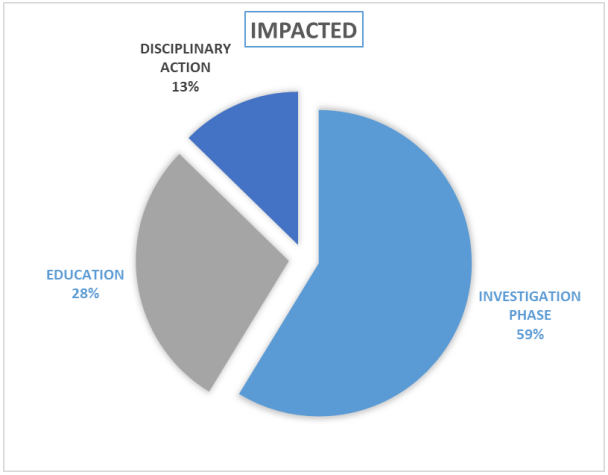
FWA Case Outcomes

Myers and Stauffer reviewed the actions and outcomes AGP reported for the 168 FWA cases active during the study period. We categorized final actions and outcomes for all cases, regardless of open versus closed status. FWA cases impacted by the DCH COVID-19 stand-down order tended to have outcomes skewed more towards investigative phases (suspended or unresolved) and education, and away from disciplinary and legal actions.

Figure 6: FWA Case Outcomes – Not Impacted

Figure 7: FWA Case Outcomes – Impacted





Completeness and Consistency of FWA Reporting

During our review of the four quarterly FWA reports, we found AGP's reporting to be complete, orderly, and consistent.

Recommendations

Myers and Stauffer has the following recommendations for AGP SIU:

- *Carefully review all FWA cases closed during the DCH COVID-19 stand-down period to assess the need to resume some of these cases.*
- *Increase data mining of encounters that occurred during calendar years 2020 and 2021 to search for fraud and abuse that may have been missed due to the DCH COVID-19 stand-down orders.*

Contract Compliance – Georgia Families 360°

This section of the report provides an overview of AGP's Georgia Families 360° contract compliance. We performed an assessment of the operational areas of care coordination, member enrollment and dis-enrollment, internal grievances and appeals, member call center, provider network, quality improvement, required assessment and screenings, and UM. We identified the key contractual requirements, then determined whether AGP's policies and procedures were in compliance with the DCH contract outlined in *Appendix D: Georgia Families 360° Policy and Procedure Review*.

Care Coordination

Overview of Georgia Families 360° Care Coordination

Section 4.11.8.15 of the contract requires AGP to implement an approach to care coordination that employs person-centered strategies, collaboration with DCH and sister agencies, and does not focus solely on the member's immediate health care needs. Further, AGP shall provide care coordination services that are comprehensive and timely. Coordination activities include actively linking the member to providers, medical services, residential, social, and other support services or resources appropriate to the needs and goals identified in their plan of care. Coordination activities tailors care and treatment to each individual.

AGP policy and procedures indicates that all Georgia Families 360° members will have access to care coordination services and an interdisciplinary care coordination team. The care coordination team will include a care coordinator and clinical representatives to meet the individual needs of members. Care coordination representatives are assigned by regions.

Observations: Georgia Families 360° Care Coordination

- *Care coordination representatives use the Care Compass System to document communications with members, Department of Family and Children Services (DFACs), providers, etc.*
- *An analytics system identifies Intensive Members using claims history, utilization, diagrams, spending, and stratifications.*
- *Once a member is categorized as an Intensive Member, they receive an assessment within 30 days. A care plan is created based on the assessment, and it is updated every 30 days.*
- *Members remain on the Intensive Member list until they are stabilized.*
- *All face-to-face meetings have been moved to virtual due to COVID-19.*
- *The care coordination team uses the Tableau system to monitor reports and compliance.*

Assessment: Georgia Families 360° Care Coordination

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We identified the following potential issues:

- *Myers and Stauffer found there is potential for limited outreach to Georgia Families 360° members. It appears there are too many members assigned to each care coordinator to be able to make the contractual number of contacts.*

Member Enrollment and Disenrollment

Overview of Georgia Families 360° Member Enrollment and Disenrollment

Section 4.1.1.1 of the contract requires AGP to be responsible for enrolling and dis-enrolling its members, educating them on enrollment options, and developing and implementing outreach activities. AGP shall not discriminate against individuals on any basis, including but limited to religion, gender, race, color, or national origin, or on the basis of health, health status, pre-existing condition, sexual orientation, or need for health care services.

Further, AGP shall enroll members in the Georgia Families 360° program and immediately begin care coordination upon notification that the member is eligible for the Georgia Families 360° program. Members enrolled in the Georgia Families 360° program may elect to dis-enroll from the program without cause during the Adoption Assistance (AA) member fee-for-service (FFS) selection period.

AGP policy indicates that the plan is responsible for the enrollment and dis-enrollment of its members. AGP has policies and procedures designed to outreach to members that are eligible for Georgia Families 360° upon enrollment. Additionally, member dis-enrollments are processed in the claims processing system and requests for member dis-enrollments are completed in a timely manner.

Observations: Georgia Families 360° Member Enrollment and Disenrollment

- *Enrollment files are received as an 834 file through an FTP transfer.*
- *The 834 file is reconciled with state data for accuracy.*
- *CMS sends files daily and monthly with Medicare leads.*

Assessment: Georgia Families 360° Member Enrollment and Dis-Enrollment

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Internal Grievance/Appeals System

Overview of Georgia Families 360° Internal Grievance/Appeals System

Section 4.14.1 of the contract requires AGP to develop written grievance system and appeals process, policies, and procedures that detail the grievance system and appeals process. The system shall include a process to receive, track, resolve, and report on grievances from its members. Further, the appeals process shall include an administrative review process and access to the state's administrative law hearing system.

The AGP policies and procedures for internal grievances and appeals for Georgia Families 360° are consistent with the policies and procedures for internal grievances and appeals for Georgia Families.

Observations: Georgia Families 360° Internal Grievance/Appeals System

- *The team consists of staff who handle the grievances and appeals.*
- *The appeals and grievances are assigned to the staff by an intake coordination.*
- *The appeals and grievances can come in by email, letter, customer service line, or the web portal.*
- *During the appeal process, AGP provides the opportunity to present evidence, written comments, documents or other information and allegations of fact or law in person as well as in writing at any time.*
- *The team has 30 days to provide resolution or a decision regarding the appeal or grievance.*
- *Monthly and quarterly reports are provided to AGP by a CGA team.*

Assessment: Georgia Families 360° Internal Grievance/Appeals System

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Member Call Center

Overview of Georgia Families 360° Member Call Center

Section 4.3.8 of the Contract requires AGP to provide a twenty-four (24) hour call center staffed with experienced staff familiar with GF 360°, Georgia child-serving agencies, and the Georgia provider community. *Table 12* below lists the child-serving agencies utilized by AGP.

The call center shall be staffed and trained to accurately assist members with general inquiries, identify the need for crisis intervention, and provide referrals to Georgia crisis and access line and/or other resources for crisis and emergent needs. Additionally, the call center shall develop call center policies

and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The call center shall achieve performance standards and monitor call center performance by recording calls and employing other monitoring activities.

Table 2: Child-Serving Agencies in Georgia

Child-Serving Agencies in Georgia		
Agency Name	**Agency Type**	
	State	**Partner Organization**
American Academy of Pediatrics-Georgia Chapter (Georgia-AAP)		✓
Amerigroup Community Care		✓
CareSource		✓
Centene		✓
Center for Leadership in Disability, Georgia State University		✓
Center of Excellence for Children's Behavioral Health (COE), Georgia State University		✓
Children's Healthcare of Atlanta (CHOA)		✓
Georgia Alliance of Therapeutic Services for Children and Families (GATS)		✓
Georgia Appleseed Center for Law and Justice		✓
Georgia Association of Community Service Boards (GACSB)		✓
Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)	✓	
Georgia Department of Community Health (DCH)	✓	
Georgia Department of Early Care and Learning (DECAL)	✓	
Georgia Department of Education (DOE)	✓	
Georgia Department of Human Services (DHS), Division of Family and Children Services (DFCS)	✓	
Georgia Department of Juvenile Justice (DJJ)	✓	
Georgia Department of Public Health (DPH)	✓	
Georgia Early Education Alliance for Ready Students (GEEARS)		✓
Georgia Family Connection Partnership		✓
Georgia Parent Support Network (GPSN)		✓
Georgia Vocational Rehabilitation Agency (GVRA)	✓	
Mental Health America of Georgia		✓
National Alliance on Mental Illness (NAMI) – Georgia		✓
Peach State		✓
Resilient Georgia		✓
The Carter Center		✓
Together Georgia		✓
United Way of Greater Atlanta		✓
View Point Health Care Management Entity		✓

Child-Serving Agencies in Georgia		
Agency Name	Agency Type	
	State	Partner Organization
Voices for Georgia's Children	☐	✓
WinGeorgia Care Management Entity	☐	✓

AGP policies and procedures indicated that a call center team staffed 24/7 with Anthem personal guides serving the members, child-serving agencies, and the Georgia provider community. The policies outline the standard operating procedures for compliance with the contractual metrics, call handling, and daily operations.

Observations: Georgia Families 360° Member Call Center

- *The call center is made up of directors, managers, and associates.*
- *New associates go through six weeks of training.*
- *Each associate receives two quality assurance audits per month.*
- *There are English and Spanish speaking associates available.*
- *The managers and directors review reports daily of the performance metrics.*
- *The call center operates 24/7.*

Assessment: Georgia Families 360° Member Call Center

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Provider Network

Overview of Georgia Families 360° Provider Network

Section 4.8.1 of the contract requires AGP to develop and maintain a network of providers and facilities adequate to deliver covered services while ensuring adequate and appropriate provision of services to members in rural areas. Further, AGP is responsible for providing a network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, and speech therapists. AGP must expand upon its Georgia Families provider network to meet the unique needs of the members.

AGP policy indicates that the plan has established comprehensive mechanisms to ensure an adequate network of primary, behavioral, and specialty care to include high-volume and high-impact practitioners, therapists (aquatic, physical, occupational, speech therapists), facilities, and border providers, as well as other providers for its membership.

Observations: Georgia Families 360° Provider Network

- *The manager of the provider network team is responsible for contracting new providers and updating existing contracts.*
- *All provider information is validated by the operations department.*
- *The provider network team can receive recruitment leads or the provider can reach out to the team directly.*
- *The provider network team has 48 hours to complete single case agreements.*
- *The provider network team uses a template received from the State to complete the geo-access report quarterly.*

Assessment: Georgia Families 360° Provider Network

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Quality Improvement

Overview of Georgia Families 360° Quality Improvement

Section 4.12.1 of the contract requires AGP to provide for the delivery of quality care with the primary goal of improving the health status of members and where the member's condition is not amenable to improvement, and maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. Further, AGP shall obtain National Committee for Quality Assurance (NCQA) interim status. Additionally, AGP shall establish a Quality Oversight Committee to oversee all quality functions and activities.

AGP's policy indicates that the Quality Strategic Plan is designed to improve the quality of care and service rendered to Georgia Families and Georgia Families 360° members. AGP has established a Quality Improvement Committee to review, approve, and make recommendations related to the quality, safety, accessibility, and availability of care and services.

Observations: Georgia Families 360° Quality Improvement

- *Monthly reports are used to measure Healthcare Effectiveness Data and Information Set and performance measures.*
- *Patient safety audits are conducted for quality of care.*
- *There are semi-annual Georgia Families 360° audits.*
- *There are staff members assigned regionally to roughly 30,000 members.*

Assessment: Georgia Families 360° Quality Improvement

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Required Assessments and Screenings

Overview of Georgia Families 360° Required Assessments and Screenings

Section 4.7.7.3.1.a states that AGP must successfully conduct and report required assessments and screenings among member enrollment. AGP must assess the need to complete a new screening each time a member moves to a new placement or based on the change in the member's medical or behavioral health as identified by providers.

AGP policies and procedures indicate the required assessments and screenings are being performed. The assessments and screenings are used by AGP to identify the immediate needs of members transitioning into and out of Georgia Families 360°.

Observations: Georgia Families 360° Required Assessments and Screenings

- *Health screening examinations are used to identify suspected health problems.*
- *Health screening examinations indicate the need for further evaluation or referral for further diagnosis.*
- *The initial assessment required before a member is placed for adoption or in foster care includes the initial physical health, dental health, and mental health screenings.*
- *Children receive periodic health screenings through the EPSDT/Georgia Health Check program.*

Assessment: Georgia Families 360° Required Assessments and Screenings

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Utilization Management

Overview of Georgia Families 360° Utilization Management

Section 4.11.1. of the contract requires AGP to implement UM processes to ensure a high quality and clinically-appropriate, yet highly-efficient and cost-effective delivery system. AGP shall continually evaluate the cost and quality of medical services provided by the providers and identify potential under and over-utilization of clinical services. Further, AGP should provide assistance to members and providers to ensure the appropriate utilization of resources, using the following program components: prior authorization and pre-certification, prospective review, concurrent review, retrospective review, ambulatory review, and second opinion.

Observations: Georgia Families 360° Utilization Management

- *The process of denial and approval is consistent with Georgia Families UM with the addition of care coordination.*
- *The UM team is made up of nurses and non-clinical staff.*
- *UM cases have a turnaround time of three days.*
- *The expedited cases have a turnaround time of 24 hours.*
- *High-dollar claims are considered to be claims that are equal to or more than $2,000.00.*
- *The UM report is sent to DCH quarterly.*

Assessment: Georgia Families 360° Utilization Management

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We determined AGP operations were in accordance with the DCH contract.

Subcontractor Oversight

This section of the report provides an overview of AGP's subcontractor oversight. We performed an assessment of AGP's policies and procedures for subcontractor oversight. We identified the key contractual requirements, then determined whether AGP's policies and procedures were in compliance with the DCH contract outlined in *Appendix C*: *Contract Compliance*.

In the contract between DCH and the CMO, Sections 18.1.1 and 18.1.3 through 18.1.6 outline the use of subcontractors in the Georgia Families program. The CMO is required to conduct ongoing monitoring of each subcontractor's performance and perform scheduled periodic reviews. AGP's subcontractors with delegated function are represented in the *Table 3* below.

Table 3: AGP Subcontractors

AGP Subcontractors						
Delegated Function	**AIM Specialty**	**Avesis**	**CVS/ Caremark**	**DentaQuest**	**IngenioRx**	**One Source**
Claims Adjudication		X	X	X	X	
Credentialing/ Re-Credentialing				X	X	
Call Center Operations	X			X		
Drug Rebate Management					X	
FWA		X				
Home Delivery Pharmacy			X		X	
Member Services		X	X		X	
PBM			X		X	
Provider Network Management		X	X	X		
Provider Services		X				
Reporting and Analytics			X		X	
Specialty Pharmacy			X		X	
UM	X	X		X		X

Assessment: Subcontractor Oversight

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We identified the following potential issues:

- *Virtual interview responses indicated that AGP is not auditing or validating the data found in the oversight reports that they receive from subcontractors.*

AIM Specialty

Overview of AIM Specialty

Section 4.7.4 of the contract requires AGP to provide diagnostic and treatment services. If a problem is detected by a preventative health screening, the member shall be evaluated and diagnosed. The member may be provided with cost-effective, medically-appropriate and necessary services to address the newly diagnosed health issue.

AIM Specialty is contracted by AGP to provide UM services for diagnostic imaging and a consultation management call center. The specific activities and responsibilities delegated to AIM Specialty are outlined in the contract with AGP.

Observations: AIM Specialty

- *The UM team is made of nurses that complete the requests based on clinical guidelines.*
- *AIM Specialty is accredited by NCQA.*
- *Genetic testing is delegated to Informed DNA.*
- *Providers can request a prior authorization via letter, web portal, or phone.*
- *An internal audit team audits the reviews and provides the results on a monthly basis.*
- *The call center is staffed with referral specialists who receive calls from providers.*
- *Calls are internally audited monthly and coaching is provided when errors are occurred.*
- *AIM Specialty has monthly meetings with AGP to discuss performance metrics.*
- *AIM Specialty has quarterly meetings with AGP to discuss financial performance.*

Assessment: AIM Specialty

Myers and Stauffer evaluated subcontractor operations utilizing the submitted policies and procedures, documentation, and interviews. We determined AIM Specialty operations were in accordance with DCH contract requirements.

Avesis

Overview of Avesis

Section 4.7.4.5 of the contract requires AGP to provide medical and routine vision services to its members. Avesis is contracted by AGP to provide vision services to its members. The specific activities and responsibilities delegated to Avesis are outlined in the contract with AGP.

Observations: Avesis

- *Avesis is delegated to perform FWA, claims and encounters, provider network, reporting, UM, and customer service.*
- *There are monthly delegation oversight meetings between Avesis and AGP to discuss the previous month's performance.*
- *Avesis performs FWA analysis on the front end of the claims cycle, before the payment of the claim.*
- *Due to COVID-19, Avesis employees transitioned to working from home and added telemedicine as an option for members.*

Assessment: Avesis

Myers and Stauffer evaluated subcontractor operations utilizing the submitted policies and procedures, documentation, and interviews. We determined Avesis operations were in accordance with DCH contract requirements.

CVS/Caremark

Overview of CVS/Caremark

Section 4.6.6. of the contract requires AGP to provide pharmacy services either directly or through a PBM to its members. A preferred drug list, utilization limits and conditions for coverage for prior authorization drugs must be available through its website.

CVS/Caremark is contracted by AGP to provide pharmacy services to its members. Further, CVS/Caremark contracts IngenioRx for specialty services. The specific activities and responsibilities delegated to CVS/Caremark are outlined in the contract with AGP.

Observations: CVS/Caremark

- *CVS/Caremark provides delegated pharmacy benefit management and administrative services for specialty drugs to IngenioRx and its customers.*
- *There is a team within CVS/Caremark that is dedicated to MAC.*
- *CVS/Caremark receives a daily file from IngenioRx of pharmacies that are enrolled with the State.*
- *Quarterly geo-access reports are run to ensure network adequacy.*
- *Quality assurance is performed on claims by taking adjudicated claims to ensure the claims meet the requirements and specifications.*

Assessment: CVS/Caremark

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We identified the following potential issues:

- *Myers and Stauffer observed potentially missing paid and denied CVS/Caremark encounters in the MMIS.*
- *Myers and Stauffer observed mismatching claim data elements between the CVS/Caremark extracts and the MMIS encounters.*
- *CVS/Caremark did not provide a clear demonstration of their pricing processes and/or procedures.*
- *While interviewing with CVS/Caremark, we were denied a demonstration and request to review their encounter submission system or dashboard, stating "proprietary" reasons.*

DentaQuest

Overview of DentaQuest

Section 1.0.1.1 of the contract requires AGP to provide covered dental services to its members. Their network may contain primary dental providers (PDPs) who are able and willing to carry out all dentist responsibilities compliant with the contract provisions and licensure requirements. The PDP is responsible for coordinating referrals, when needed, to dental subspecialty providers and providing all subsequent dental care.

DentaQuest is contracted by AGP to provide dental services to its members. The specific activities and responsibilities delegated to DentaQuest are outlined in the contract with AGP.

Observations: DentaQuest

- *DentaQuest has a dedicated member line for AGP; however the staff is not dedicated and therefore takes calls for multiple clients.*
- *Call center agents are audited eight times per month.*
- *DentaQuest did not report having any CAPS in 2021.*
- *Provider Partners are responsible for 20 virtual provider visits per month. The visits are virtual due to the COVID-19 pandemic.*
- *DentaQuest accepts hand written claims, however, they are not included in the service level agreements.*
- *DentaQuest will be implementing a pay and chase program with HMS in the future.*

Assessment: DentaQuest

Myers and Stauffer evaluated this contractual area utilizing the submitted policies and procedures, documentation, and interviews. We identified the following potential issue:

- *Myers and Stauffer found that there is potential for missing original claims in the encounters because in-cycle adjustments are not identified during the encounter submission process.*

One Source Therapy Review

Overview of One Source

Section 4.8.1.1 of the contract requires AGP to include physical therapists, occupational therapists, and speech therapists in its network to provide covered therapy services to its members.

One Source is contracted by AGP to provide physical therapy, occupational therapy, and speech therapy services to its members. The specific activities and responsibilities delegated to One Source are outlined in the contract with AGP.

Observations: One Source

- *One Source completes all of the UM reviews for physical therapy, occupational therapy, and speech therapy.*
- *There are policies and procedures for annual training of the staff on the UM team.*
- *UM decisions are made following the NCQA guidelines.*
- *There are monthly meetings with AGP to report on performance and issues.*

Assessment: One Source

Myers and Stauffer evaluated subcontractor operations utilizing the submitted policies and procedures, documentation, and interviews. We determined One Source operations were in accordance with DCH contract requirements.

IngenioRx

Overview of IngenioRx

Section 4.6.6.2 of the contract requires AGP to provide pharmacy services including specialty pharmacy services to its members.

IngenioRx is contracted by CVS to provide specialty pharmacy services to its members. The specific activities and responsibilities delegated to IngenioRx are outlined in the contract with AGP.

Observations: IngenioRx

- *IngenioRx is contracted by CVS retail network contracting, specialty pharmacy, home delivery, member experience, claims processing, and reporting and analytics.*
- *Prior authorizations can come through fax, electronic portal, letter, or phone call from the member or provider.*
- *IngenioRx has a dedicated team that oversees the CVS network.*
- *IngenioRx receives a monthly pharmacy network file from CVS for geo-access reporting purposes.*
- *IngenioRx and CVS/Caremark have bi-weekly status meeting to discuss contract compliance.*

Assessment: IngenioRx

Myers and Stauffer evaluated subcontractor operations utilizing the submitted policies and procedures, documentation, and interviews. We determined IngenioRx operations were in accordance with DCH contract requirements.

Encounter Submissions and Payment Systems

Myers and Stauffer reviewed the policies and procedures for encounter submissions provided by DCH, AGP, and any related subcontractors. In *Appendix C: Contract Compliance*, we identify the key contract requirements and whether AGP has policies and procedures compliant with the contract requirement(s).

Approach and Methodology

Overview

Myers and Stauffer's review of AGP's claims and encounters management included analyzing the consistency and completeness of data across the claim/encounter life cycle.

One of the primary responsibilities of CMOs and their subcontractors is to accept and adjudicate claims payments for beneficiaries participating in the Georgia Families program. In order for the State to effectively manage the overall Medicaid program and to conform to regulatory requirements, it must have a complete and accurate record of all the adjudications under its purview, regardless of their outcome. Encounters are records of these adjudications, and each CMO and its subcontractors are contractually required to submit complete, accurate, and timely encounters to the MMIS, and to address curing encounters that have been rejected by the MMIS. Failure to do so impacts the State's analysis, decision making, rate setting, and regulatory reporting.

As part of the engagement, Myers and Stauffer reviewed the organizational teams and systems responsible for handling the claims life cycle. This review started with the receipt of provider billings, their adjudication, and their eventual submission to the State as encounters. Our objective was to identify any gaps that had the potential for impacting claims or encounters processing, information, completeness, timeliness, or accuracy. Our review was performed via interviews of responsible personnel, and by analysis of sample claims and encounters.

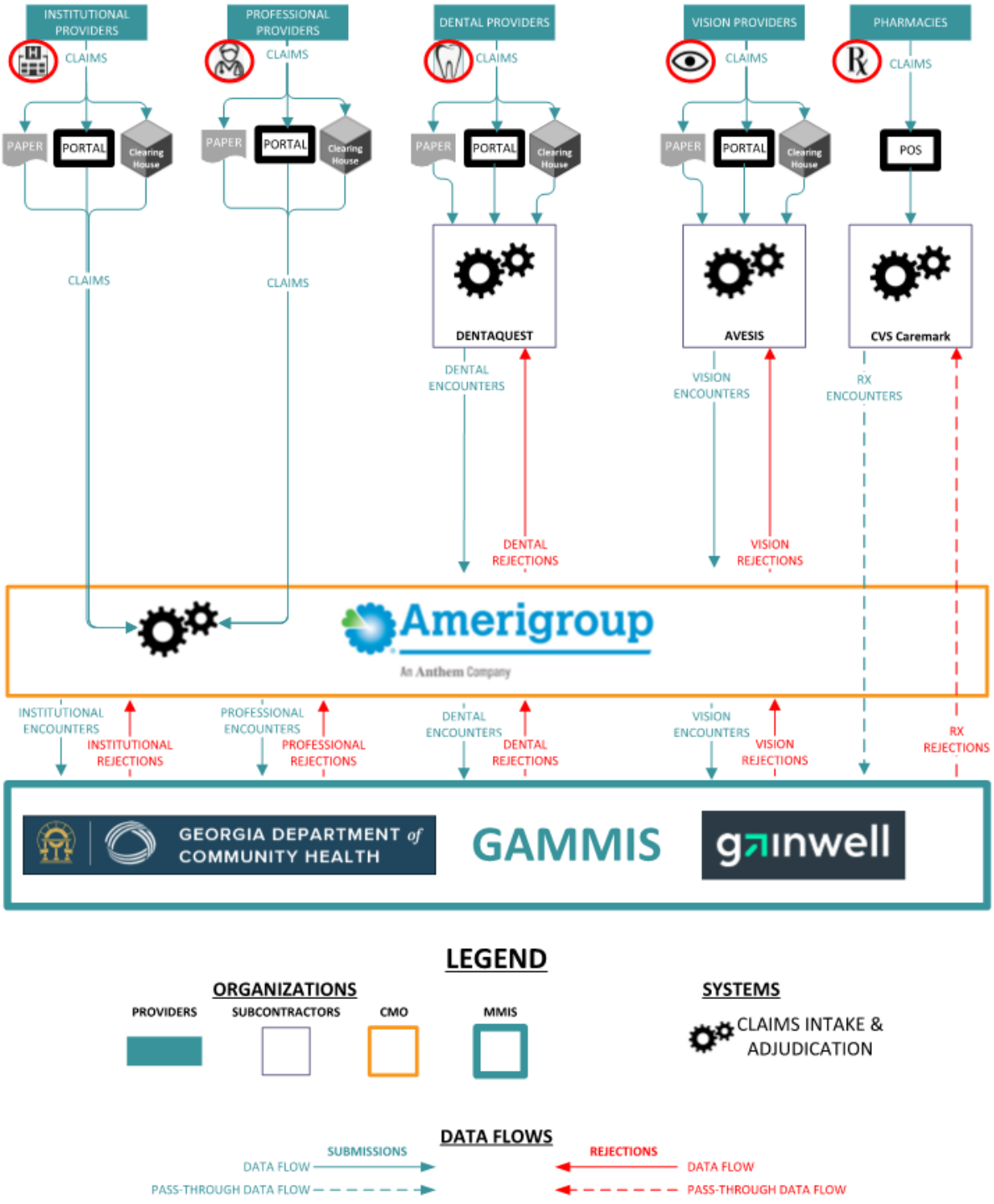
The analysis was limited to claims and encounters for member populations covered by AGP having a service date during December 2020 or a paid date in January 2021. The CMO and its subcontractors were requested to provide all claims satisfying this criteria regardless of outcome (paid, denied, or rejected) or version (original, adjusted, voided, replaced, or final).

Myers and Stauffer receives encounter data on a weekly basis from DCH's fiscal agent contractor (FAC), Gainwell. This data extract contains paid and denied CMO institutional, medical, dental, and pharmacy encounters that are submitted by the CMO to the FAC and are subsequently loaded into the MMIS. Unless conflicting information is presented to the contrary, we accept the encounter data as complete and accurate.

Myers and Stauffer mapped the claim/encounter data flow from subcontractor to the CMO and into the MMIS by linking related claim lines at the different processing points in the claim life cycle. Claim lines were linked using a combination of unique data fields, where available, and populated. Care was taken to differentiate between multiple versions and adjustments of each claim.

The following diagram depicts the claim/encounter life cycle through the subcontractors' and the CMOs' information systems.

Figure 8: Claims and Encounters Data Flow Diagram



Claims/Encounters Completeness

DCH relies on MMIS encounter claims data to perform many important functions, including, but not limited to:

- *CMO capitation rate setting.*
- *Managed care oversight.*
- *Medicaid PI initiatives.*

CMOs are contractually required to submit complete, accurate, and timely encounter data to the MMIS. To estimate the completeness of member encounter data in the MMIS, Myers and Stauffer reviewed a sample of claims from the CMO and each of their subcontractors' claims processing systems. We compared individual claim lines in these claims to individual claim lines in a sample of the State's MMIS encounters for the same sample criteria.

Encounter submission completeness analysis is presented in each section below devoted to our observations and recommendations for specific subcontractors. Claims existence is expressed as a percentage of the sampled claims appearing at multiple points in the claim/encounter life cycle.

- *Percentage of sampled lines appearing only in the CMO and subcontractor claims.*
- *Percentage of sampled lines appearing only in the State's MMIS encounters.*
- *Percentage of sampled lines appearing both in the CMO and subcontractor claims, and in the State's MMIS encounters.*

The expected outcome is that all fully adjudicated sampled claims would appear both in the CMO and subcontractor claims, and in the State's MMIS encounters. This would imply the State's MMIS encounters are a complete record of all claims processed by the CMO and its subcontractors. However, there can be multiple explanations for the existence of records in only one data source, including, but not limited to:

- ***Missing MMIS Encounters.*** *CMO and subcontractor claims were not submitted to the MMIS encounters or were rejected by the MMIS. Typically, these instances can be further broken down into the following:*
  - ***Missing Claims.*** *Claims with no representation in the MMIS encounters. These instances may understate payments and services reported in the MMIS.*
  - ***Missing Claim Adjustments.*** *Claims having one or more adjustments or versions reported in the MMIS encounters, and one or more adjustments or versions missing from the MMIS encounters. These instances may impact the accuracy of payments and services reported in the MMIS.*

- ***Missing Claim Voids.*** *Replaced or voided claims which appear to be reported in the MMIS encounters, but do not appear to be voided in the MMIS encounters. These instances may overstate payments and services reported in the MMIS.*

- ***Missing Claims in the CMO and Subcontractor Extracts.*** *The CMO or its subcontractors did not provide all data records from their systems for the requested sample criteria.*

- ***Encounter Data Field Errors.*** *Potential discrepancies in claim data element values reported in the MMIS encounters may impact which MMIS encounters are reviewed for the specified sample criteria. For example, if the service date is reported incorrectly in the MMIS encounters, some claims might not be included in the reviewed sample of MMIS encounters.*

- ***Analysis Limitations.*** *Myers and Stauffer has developed detailed logic to match and compare data records between the CMO and subcontractor's claims and MMIS encounters. In some instances this logic may fail to match records or mismatch records between the data sources. Myers and Stauffer performs random sampling and manual review of records that do not appear to exist in both the CMO and subcontractor's claims and MMIS encounters to ensure this issue is minimized.*

Myers and Stauffer further reviewed sampled claims appearing only in the CMO and subcontractor claims, and those appearing only in the MMIS encounters. We attempted to further classify these claims and provide additional details to better understand potential deficiencies in the MMIS encounters.

Encounter Submission Accuracy

Myers and Stauffer compared data elements in the CMO and subcontractor claims to related encounter data within the claim/encounter life cycle to determine if the information in the originating system ultimately matched the information reported in the MMIS. We evaluated and documented differences in claim element values, including missing values. Results were tallied for percent of matching values, broken out by vendor, claim type, and data element. Our observations and recommendations concerning potential encounter accuracy issues for specific subcontractors are addressed in each section below. Additional detail is available in *Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems*.

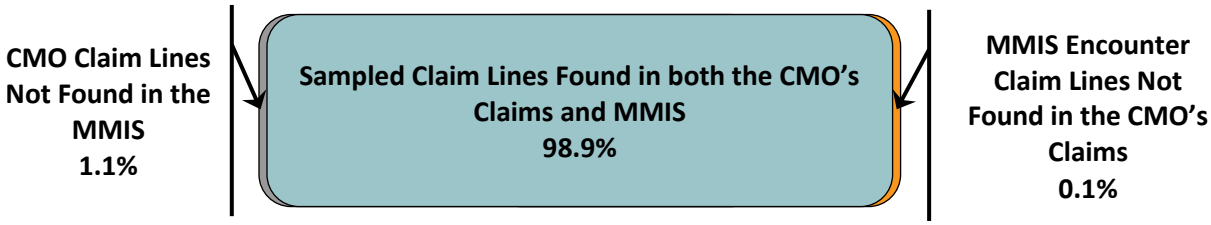
FFS Claims, Institutional and Professional – AGP

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 2.1 million claim lines adjudicated by Amerigroup for institutional and professional FFS claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled CMO claim lines were compared to MMIS encounters, and the percentage of lines appearing in both data sources or appearing in only one data source is outlined in *Table 4* below. The percentage of

sampled lines appearing only in the CMO claims and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2 percent.

Table 4: Encounter Submission Completeness: AGP



Encounter Submission Completeness	
98.9%†	**Percentage of sampled lines appearing in both the CMO's claims and the State's MMIS encounters.**
1.1%	**Percentage of sampled lines appearing only in the CMO's claims.**
	• ***Alternative Found (0.5%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Denied (0.4%)*** *– A claim line denied for payment by the CMO during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Other (0.2%)*** *– A claim line with insufficient information available to explain their absence as an encounter.*
0.1%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the CMO's claims.*

†Note, percentages are rounded and may not always add to 100%.

CMO's claims not found in the MMIS encounters:

- ***Alternative Found.*** *Approximately 11,600 (0.5 percent) AGP FFS claim lines in the CMO's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line was found in the MMIS. Many of these claims lines (approximately 9,000; 0.4 percent) appear to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS. Approximately 2,100 (0.1 percent) additional claim lines appear to have been adjudicated within seven days of the associated version identified in the MMIS. These claim lines may have been adjusted within the CMO's weekly cycle for encounter submissions and AGP may have only submitted the most recent claim adjustment to the MMIS.*
- ***Denied.*** *Approximately 8,100 (0.4 percent) AGP FFS claim lines appear to be denied in the CMO's claims but do not appear to exist in the MMIS. Although we observed a subset of denied FFS*

claims in the MMIS encounters, it appears that AGP may not be submitting all denied encounter claim lines to the MMIS.

- ***Other.*** *Approximately 4,200 (0.2 percent) AGP FFS claim lines in the CMO's claims did not appear to exist as encounter claim lines in the MMIS. The majority of these claim lines (approximately 3,500; 0.2 percent) were flagged as rejected by the MMIS, implying encounter submission was attempted but unsuccessful. There is no additional information present to explain the absence of these claim lines from the MMIS.*

Encounter Submission Accuracy

Myers and Stauffer reviewed claim lines which appeared to exist in both the CMO's claims and MMIS encounters. We compared data values reported in each data source for a series of claim data elements and calculated the percentage of lines with matching data values for each data element.

Myers and Stauffer observed the following AGP data elements whose inaccuracy could have concerning impact on the use of encounters for program management, PI, and regulatory reporting.

- ***Date Claim Submitted to AGP by the Provider*** *(institutional and professional encounters). The claim receipt date in the MMIS encounters appeared to have been consistently misreported to be the same as the claim's paid date.*
- ***Amount Paid, Claim Detail Lines*** *(institutional and professional encounters). Approximately 1.4 percent of detail lines in the AGP encounters had paid amounts that did not match the value in AGP's claim extracts. These discrepancies took a number of forms, among them the occurrence of line bundling, the amount paid at the header level not equaling the sum of the detail lines, and the inclusion/exclusion of interest payments in claims but not encounters.*
- ***Interest Paid*** *(institutional and professional encounters). We observed approximately 3.1 percent of the detail lines in the MMIS encounters for AGP for which the provider interest paid amount appeared to be missing or did not appear to be separately reported.*
- ***Attending Provider National Provider Identifier (NPI)*** *(institutional encounters only). For approximately 76.4 percent of the detail lines in the MMIS encounters for AGP, attending provider NPI appeared to be reported in the claims extracts but appeared to be missing in the MMIS encounters.*
- ***Referring Provider NPI*** *(institutional and professional encounters). For approximately 47.0 percent of the detail lines in the MMIS encounters for AGP, referring provider NPI appeared to be reported in the claims extracts but appeared to be missing in the MMIS encounters.*
- ***Claim Detail Line International Classification of Diseases (ICD) Diagnosis Codes*** *(professional encounters only). For approximately 7.4 percent of the professional claim lines in the MMIS*

encounters for AGP, the claim detail line diagnosis codes did not match the values in the AGP extracts.

- ***Payee Provider Tax ID*** *(institutional and professional encounters). Approximately 5.7 percent of the detail lines in the AGP encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*
- ***Rendering Provider NPI*** *(institutional and professional encounters). For approximately 2.2 percent of the detail lines in the MMIS encounters for AGP, the rendering provider's NPI did not match the value found in the claims extracts submitted by AGP.*
- ***Last Date of Service, Claim Header*** *(institutional encounters only). For approximately 1.6 percent of the institutional claim lines in the MMIS encounters, the claim header's last date of service did not match the value in AGP's claims extracts. Rather, the claim header's last date of service appeared to be derived from claim discharge date.*

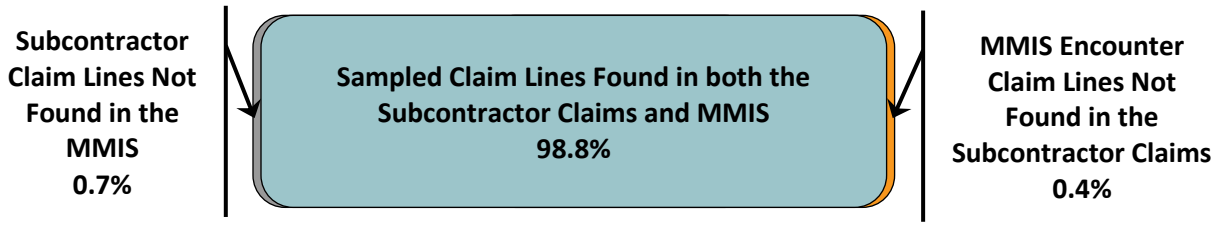
Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems comprises additional detail concerning the accuracy of all data elements reviewed for institutional encounters (*Exhibit II, Table 1*) and professional encounters (*Exhibit II, Table 2*).

Dental Claims – DentaQuest

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 417,000 claim lines adjudicated by DentaQuest for dental claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim lines were compared to MMIS encounters, and the percentage of lines appearing in both data sources or appearing in only one data source is outlined in *Table 5* below. The percentage of sampled lines appearing only in the subcontractor claims, and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2 percent.

Table 5: Encounter Submission Claim Completeness: DentaQuest



Encounter Submission Completeness	
98.8%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
0.7%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Other (0.7%)*** *– A claim line with insufficient information available to explain its absence as an encounter.*
0.4%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Alternative Found (0.3%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.* • ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.*

†Note, percentages are rounded and may not always add to 100%.

DentaQuest Dental claims not found in the MMIS encounters:

- ***Other.*** *Approximately 2,700 (0.7 percent) DentaQuest dental claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS. A subset of these claim lines (approximately 330, 0.1 percent) were flagged as rejected by the MMIS, implying encounter submission was attempted but unsuccessful. There is no additional information present to explain the absence of these claim lines from the MMIS.*

MMIS encounters not found in the DentaQuest dental claims:

- ***Alternative Found.*** *Approximately 1,100 (0.3 percent) DentaQuest dental encounter claim lines in the MMIS did not appear to exist in the subcontractor's claims; however, an alternate version or adjustment of the claim line was found in the subcontractor's claims. Most of these encounter claim lines (approximately 850; 0.2 percent) appear to have alternate versions with matching line payment amounts and matching paid dates compared to the associated version identified in the subcontractor's claims.*

Encounter Submission Accuracy

Myers and Stauffer reviewed claim lines which appeared to exist in both the subcontractor's claims and MMIS encounters. We compared data values reported in each data source for a series of claim data elements and calculated the percentage of lines with matching data values for each data element.

Myers and Stauffer observed the following DentaQuest data elements whose inaccuracy could have concerning impact on the use of encounters for program management, PI, and regulatory reporting.

- ***Date Claim Submitted to DentaQuest by the Provider.*** *The claim receipt date in the MMIS encounters appeared to have been consistently misreported as the same as the claim's paid date.*

- ***Interest Paid.*** *We normally expect interest paid amounts to be identified with an adjustment reason code. No identifiable interest amounts were observed to exist in the MMIS dental encounters for DentaQuest.*
- ***Payee Provider Tax ID.*** *Approximately 6.0 percent of the detail lines in the DentaQuest encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*
- ***Procedure Code.*** *For approximately 1.3 percent of the detail lines in the MMIS encounters for DentaQuest encounters, the procedure code did not match the value found in the claims extracts submitted by DentaQuest. For many of these claim lines, it appears the procedure code was reported in the MMIS encounters as "D0210" (Intraoral – complete series of radiographic images).*
- ***Tooth Number and Tooth Surface.*** *For approximately 4.8 percent of the detail lines in the MMIS encounters for DentaQuest encounters, the tooth number and/or tooth surface codes did not match the values found in the claims extracts submitted by DentaQuest.*

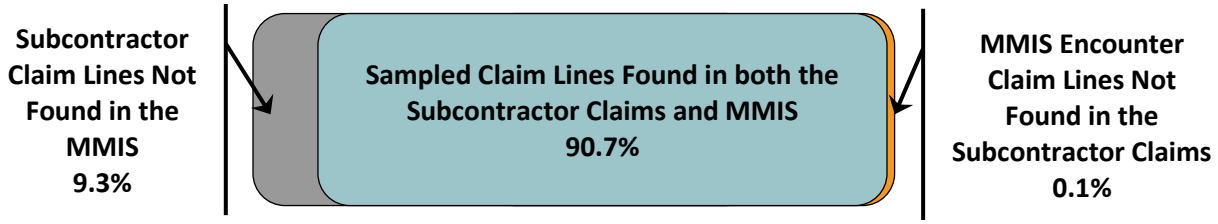
Exhibit II, Table 3 comprises additional detail concerning the accuracy of all dental data elements reviewed.

Vision Claims – Avesis Vision

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 29,600 claim lines adjudicated by Avesis Vision for vision claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim lines were compared to MMIS encounters and the percentage of lines appearing in both data sources or in only one data source is outlined in the *Table 6* below. The percentage of sampled lines appearing only in the subcontractor claims, and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2 percent.

Table 6: Encounter Submission Completeness: Avesis



Encounter Submission Completeness	
90.7%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
9.3%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Alternative Version Found (5.8%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Denied (3.4%)*** *– A claim line denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.*
0.1%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.*

†Note, percentages are rounded and may not always add to 100%.

Avesis Vision claims not found in the MMIS encounters:

- ***Alternative Found.*** *Approximately 1,700 (5.8 percent) Avesis Vision claim lines in the subcontractor's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line was found in the MMIS. Approximately 110 (0.4 percent) appear to have alternate versions with matching line payment amounts when compared to the associated version identified in the MMIS. Approximately 450 (1.5 percent) additional claim lines appear to have been adjudicated within seven days of the associated version identified in the MMIS. These claim lines may have been adjusted within the subcontractor's weekly cycle for encounter submissions and Avesis Vision may have only submitted the most recent claim adjustment to the MMIS.*
- ***Denied.*** *Approximately 1,000 (3.4 percent) Avesis Vision claim lines appear to be denied in the subcontractor's claims but do not appear to exist in the MMIS. Although we observed a small subset of denied vision claims in the MMIS encounters, it appears that Avesis Vision may not be submitting all denied encounter claim lines to the MMIS.*

Encounter Submission Accuracy

Myers and Stauffer reviewed claim lines which appeared to exist in both the subcontractor's claims and MMIS encounters. We compared data values reported in each data source for a series of claim data elements and calculated the percentage of lines with matching data values for each data element.

Myers and Stauffer observed the following Avesis Vision data elements whose inaccuracy could have concerning impact on the use of encounters for program management, PI, and regulatory reporting.

- ***Date Claim Submitted to Avesis Vision by the Provider.*** *The claim receipt date in the MMIS encounters appeared to have been consistently misreported to be the same as the claim's paid date.*
- ***Amount Paid, Claim Header.*** *For approximately 1.2 percent of the detail lines in the MMIS encounters for Avesis Vision, the claim header paid amount did not match the value found in the claims extracts submitted by Avesis Vision.*
- ***Interest Paid.*** *We normally expect interest paid amounts to be identified with an adjustment reason code. No identifiable interest amounts were observed to exist in the MMIS vision encounters for Avesis Vision.*
- ***Place of Service.*** *The place of service code in the MMIS encounters appears to have been hard-coded to a value of "11" (office) for all Avesis Vision encounters. The place of service code reported in the MMIS encounters may not accurately reflect the setting in which a service was provided.*
- ***Claim Detail Line ICD Diagnosis Codes.*** *Line diagnosis code pointers for Avesis Vision encounters appear to have been hard-coded to values "1," "2," and "3" for all Avesis Vision encounters. The line ICD diagnosis codes reported in the MMIS encounters may not accurately reflect the relevant diagnosis codes for the detail line service provided.*
- ***Payee Provider Tax ID.*** *Approximately 5.1 percent of the detail lines in the Avesis Vision encounters appeared to have payee provider tax IDs that were derived from the claim's rendering provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*

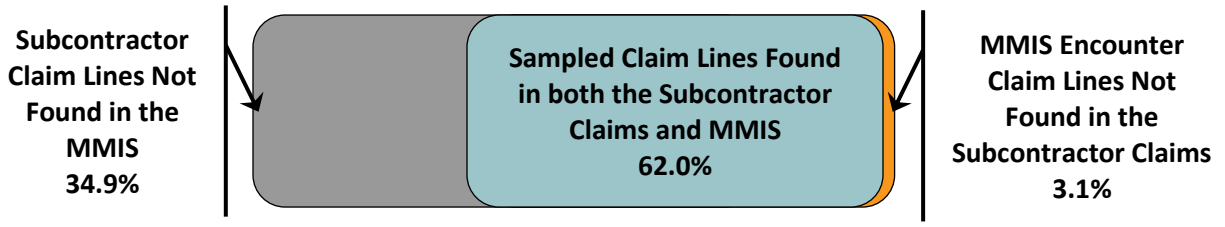
Exhibit II, Table 4 comprises additional detail concerning the accuracy of all vision data elements reviewed.

Pharmaceutical Claims – CVS/Caremark

Encounter Submission Completeness

Myers and Stauffer reviewed approximately 686,300 claim lines adjudicated by CVS/Caremark for pharmaceutical claims. Encounter submission completeness is expressed as a percentage of the sampled claim lines appearing at multiple points in the claim/encounter life cycle. Sampled subcontractor claim lines were compared to MMIS encounters and the percentage of lines appearing in both data sources or appearing in only one data source is outlined in *Table 7* below. The percentage of sampled lines appearing only in the subcontractor claims, and the percentage of sampled lines appearing only in the MMIS encounters are further broken out in the bullets below each percentage. Additional observations are provided in the following section for percentages greater than 0.2 percent.

Table 7: Encounter Submission Completeness: CVS/Caremark



Encounter Submission Completeness	
62.0%†	**Percentage of sampled lines appearing in both the subcontractor's claims and the State's MMIS encounters.**
34.9%	**Percentage of sampled lines appearing only in the subcontractor's claims.**
	• ***Rejected or Denied (33.1%)*** *– A claim line rejected or denied for payment by the subcontractor during their claim adjudication process due to authorization, eligibility, limits issues, or other reasons.* • ***Alternative Version Found (1.6%)*** *– Claim lines that did not appear to exist as encounters for which a different version or adjustment was found.* • ***Other (0.2%)*** *– A claim line with insufficient information available to explain its absence as an encounter.*
3.1%	**Percentage of sampled lines appearing only in the State's MMIS encounters.**
	• ***Alternative Found (3.1%)*** *– Encounter lines that did not appear to exist as claim lines for which a different version or adjustment was found.* • ***Other (0.1%)*** *– An encounter line with insufficient information available to explain its absence from the subcontractor's claims.*

†Note, percentages are rounded and may not always add to 100%.

CVS/Caremark claims not found in the MMIS encounters:

- ***Rejected or Denied.*** *Approximately 227,000 (33.1 percent) CVS/Caremark pharmaceutical claim lines appear to be rejected or denied in the subcontractor's claims, but do not appear to exist in the MMIS. It appears that CVS/Caremark may not be submitting all rejected or denied encounter claim lines to the MMIS.*
- ***Alternative Found.*** *Approximately 11,100 (1.6 percent) CVS/Caremark pharmaceutical claim lines in the subcontractor's claims did not appear to exist in the MMIS; however, an alternate version or adjustment of the claim line was found in the MMIS. Approximately 11,000 (1.6 percent) claim lines appear to have been adjudicated within seven days of the associated version identified in the MMIS. These claim lines may have been adjusted within the subcontractor's weekly cycle for encounter submissions and CVS/Caremark may have only submitted the most recent claim adjustment to the MMIS.*
- ***Other.*** *Approximately 1,400 (0.2 percent) CVS/Caremark pharmaceutical claim lines in the subcontractor's claims did not appear to exist as encounter claim lines in the MMIS and there is no information present to explain the absence from the MMIS.*

MMIS encounters not found in the CVS/Caremark claims:

- ***Alternative Found.*** *Approximately 21,100 (3.1 percent) CVS/Caremark pharmaceutical encounter claim lines in the MMIS did not appear to exist in the subcontractor's claims; however, an alternate version or adjustment of the claim line was found in the subcontractor's claims. Some of these encounter claim lines (approximately 10,600; 1.6 percent) appear to have alternate versions with matching line payment amounts and matching paid dates compared to the associated version identified in the subcontractor's claims.*

Encounter Submission Accuracy

Myers and Stauffer reviewed claim lines which appeared to exist in both the subcontractor's claims and MMIS encounters. We compared data values reported in each data source for a series of claim data elements and calculated the percentage of lines with matching data values for each data element.

Myers and Stauffer observed the following CVS/Caremark data elements whose inaccuracy could have concerning impact on the use of encounters for program management, PI, and regulatory reporting.

- ***Date Claim Submitted to CVS/Caremark by the Provider.*** *For approximately 2.5 percent of the MMIS encounters for CVS/Caremark, the claim submission date did not match the value found in the claims extracts submitted by CVS/Caremark.*
- ***Amount Billed.*** *The billed amount reported in the MMIS encounters for CVS/Caremark did not appear to match the value found in the claims extracts submitted by CVS/Caremark. The billed amount reported in the MMIS encounters appears to represent the claim paid amount.*
- ***Payee Provider Tax ID.*** *Approximately 6.3 percent of the MMIS encounters for CVS/Caremark appeared to have payee provider tax IDs that were derived from the claim's dispensing provider. They may not accurately reflect the claim payee/billing provider submitted on the claim itself.*
- ***Dispensing Provider NPI.*** *For approximately 1.3 percent of the MMIS encounters for CVS/Caremark, the dispensing provider NPI did not match the value found in the claims extracts submitted by CVS/Caremark.*

Exhibit II, Table 5 comprises additional detail concerning the accuracy of all CVS/Caremark pharmaceutical data elements reviewed.

Cash Disbursement Journal (CDJ) Verification

Introduction

DCH requires that each of their contracted CMOs submit encounter data to the FAC, Gainwell. Myers and Stauffer provides bi-monthly encounter data validations to ensure DCH is receiving complete encounter data. As part of this process, Myers and Stauffer analyzes Medicaid encounter data that has been submitted by the CMOs to Gainwell and completes a reconciliation of the encounters to CDJs provided by each CMO.

Myers and Stauffer receives CDJ files from AGP and their subcontractors on a monthly basis. These CDJ files are supposed to represent all payment transactions made by AGP and their subcontractors to providers during each month. We utilize this information as the denominator in the completeness calculation of encounter data for the Georgia Families program. The encounter reconciliation process uses CDJ files as the primary source document for encounter data validations, so it is important to independently verify the information in the CMO and subcontractor CDJ submissions periodically. In this review, we are comparing the CDJ files for a sample month to an independent financial data source to ensure the encounters are being reconciled against complete and accurate financial information in the CDJ files.

Methodology and Data Sources

In order to verify the CDJ data, Myers and Stauffer requested information from a separate accounting source (e.g., check register, bank statement, or general ledger), independent of the CDJ data, for payments and recoupments made during January 2021 (the sample month) from AGP and their subcontractors for Georgia Families.

Myers and Stauffer sent the request below to AGP in December 2021:

- *"Myers and Stauffer is requesting additional documentation to verify the CDJ data used to determine encounter completeness. Please provide a bank statement, check register, or similar accounting ledger for payments and recoupments made for AGP Georgia Medicaid members in the month of January 2021. Please reconcile this information against the CDJ file submissions for the month and document any variance you identify. Note any variance you are unable to reconcile and clarify if CDJ resubmission(s) will be necessary. Please provide the requested documentation for Medicaid claim expenditures and recoupments processed by AGP as well as its delegated vendors DentaQuest, Avesis Vision, and CVS."*

Analysis and Recommendations

The validation documentation received from AGP was compared to the AGP and subcontractor CDJ submissions for the sample month. A summary of the results of this analysis are presented in the following report sections devoted to our observations for specific subcontractors.

The results of our review of cash disbursement data for AGP and their subcontractors indicates that the sample month CDJ file submissions are materially accurate. The CDJ files appear to be appropriate to continue to use in the bi-monthly encounter to CDJ reconciliation process.

During the course of our review, we identified some potential opportunities for the implementation and/or improvement of processes by the CMOs and their subcontractors to validate their CDJ file submissions on a consistent basis. We recommend the CMOs develop financial reconciliation processes to continuously monitor the completeness and accuracy of their CDJ files submissions against independent financial sources.

FFS Claims, Institutional and Professional – AGP

AGP provided January 2021 check register details as their verification documentation. Upon review of the supplied check register details, we identified the following differences in the way payments were reported in the check register details compared to the CDJ files:

- ***Transaction Type.*** *Check register detail transactions were supplied as net payments and net reversals, in contrast to the CDJ file transactions, which are supplied as differential payments and reversals.*
- ***Payment Date.*** *The payment date in the check register details was identified as the check printed date and appeared to represent the payment posting date, in contrast to the CDJ file transaction date, which appears to represent the payment processing date.*

Due to these differences, we were unable to reliably compare the supplied AGP check register details to the CDJ files using a simple summary comparison on payment date. Instead, we reviewed individual claim payments in the check register against the history of payment transactions in the CDJ files for the same claim. We checked for potential missing transactions, duplicate transactions, and mismatched net payment amounts in the AGP CDJ files.

Reversal transactions in the check register details served the purpose of voiding prior reported payments when subsequent claim adjustments occurred. We performed a cursory quality review of check register reversal transactions, but otherwise excluded check register reversals when comparing to the CDJ files.

We summarized the check register payments by the supplied check printed date in *Table 8* below, with the corresponding matched claim payments from the CDJ files.

Table 8: Amerigroup FFS CDJ to Verification Documentation Comparison

Amerigroup FFS CDJ to Verification Documentation Comparison				
Verification Documentation		CDJ Submissions	Comparison	
Check Printed Date	Paid Amount	Calculated CDJ Net Paid Amount	Variance	Verification Percentage
1/1/2021	$160,994	$79,372	$81,622	49.3%
1/4/2021	$11,688,605	$11,688,652	-$48	100.0%
1/5/2021	$36,782	$40,253	-$3,471	109.4%
1/6/2021	$4,446,112	$4,448,459	-$2,347	100.1%
1/8/2021	$243,882	$149,419	$94,462	61.3%
1/11/2021	$11,119,826	$11,162,460	-$42,634	100.4%
1/12/2021	$1,695	$2,126	-$430	125.4%
1/13/2021	$7,945,820	$7,948,359	-$2,540	100.0%
1/15/2021	$36,555	-$31,078	$67,633	-85.0%
1/18/2021	$14,337,495	$14,404,476	-$66,982	100.5%
1/19/2021	$13,479	$11,751	$1,728	87.2%
1/20/2021	$6,605,354	$6,628,921	-$23,568	100.4%
1/21/2021	$2,288	$2,288	$0	100.0%
1/22/2021	$22,442	$21,689	$753	96.6%
1/25/2021	$10,629,138	$10,637,078	-$7,940	100.1%
1/26/2021	$34,148	$12,706	$21,443	37.2%
1/27/2021	$6,993,284	$7,013,019	-$19,734	100.3%
1/29/2021	$20,234	$10,001	$10,233	49.4%
2/1/2021	$10,286,253	$10,301,255	-$15,002	100.1%
2/2/2021	$546	$546	$0	100.0%
2/3/2021	$32,210	$44,494	-$12,285	138.1%
2/8/2021	$22,790	$22,820	-$30	100.1%
2/10/2021	$9,596	$9,596	$0	100.0%
2/15/2021	$10,122	$10,122	$0	100.0%
2/17/2021	$6,935	$6,935	$0	100.0%
TOTAL	**$84,706,584**	**$84,625,720**	**$80,865**	**99.9%**

Overall, the verification data included approximately $80,865 more in payments when compared to the CDJ files, representing a potential under-reporting of payments in the CDJ. This discrepancy is further explained below:

- *We observed approximately 322 claim iterations in the verification data where we were unable to trace the full claim payment history in the CDJ. This was due to historic payment records in the CDJ representing lump sum payments for multiple claims that could not be tied to a specific claim. The CDJ may fully capture the history of payment transactions for these claims, but we*

were unable to verify the history with available data. These claims accounted for approximately $200,000 in potential under-reported payments in the CDJ files compared to the verification data.

- *We observed approximately 510 claim iterations in the verification data where payment amounts do not appear to match claim net payment amounts reported in the CDJ. This appears to be due to potential missing payment and reversal transactions in the CDJ. These claims accounted for approximately $117,600 in potential over-reported payments in the CDJ files compared to the verification data.*
- *We observed potential duplicate payment and reversal transactions in the CDJ files for approximately 53 claim iterations. These potential duplicate transactions accounted for approximately $1,500 in potential over-reported payments in the CDJ files when compared to the verification data.*

Dental Claims – DentaQuest

DentaQuest submitted January 2021 check register details as their verification documentation. We summarized the check register payments by the supplied check date and the CDJ files by transaction date in the table below. In general, the check date reported in the DentaQuest check register details appeared to occur three days after the transaction date in the CDJ files. As a result, we compared CDJ summaries to DentaQuest summaries having check dates three days following the CDJ transaction date for the most representative comparison in *Table 9* below.

Table 9: DentaQuest Dental CDJ to Verification Documentation Comparison

DentaQuest Dental CDJ to Verification Documentation Comparison					
Verification Documentation		January 2021 CDJ Submissions		Comparison	
Check Date	Paid Amount	Transaction Date	Transaction Amount	Variance	Verification Percentage
1/5/2021	$787,210	1/2/2021	$787,242	-$32	100.0%
1/12/2021	$1,156,503	1/9/2021	$1,156,367	$136	100.0%
1/19/2021	$1,266,389	1/16/2021	$1,262,881	$3,507	99.7%
1/26/2021	$1,378,313	1/23/2021	$1,374,675	$3,638	99.7%
2/2/2021	$1,486,059	1/30/2021	$1,474,948	$11,110	99.3%
TOTAL	**$6,074,473**		**$6,056,114**	**$18,360**	**99.7%**

Overall, the verification data included approximately $18,360 more in payments when compared to the CDJ files, representing a potential under-reporting of payments in the CDJ. This discrepancy is further explained below:

- *We observed approximately 88 check payments in the verification data that do not appear to be reported in the CDJ files. These check payments accounted for approximately $11,200 in potential under-reported payments in the CDJ files when compared to the verification data.*
- *We observed approximately 484 check payments in the verification data where payment amounts do not appear to match net check payments reported in the CDJ files. These check payments accounted for approximately $7,290 in potential under-reported payments in the CDJ files when compared to the verification data.*
- *We observed approximately 137 check payments in the verification data where payment amounts do not appear to include interest payments, but where the corresponding CDJ file net payments do appear to include interest. These interest payments accounted for approximately $140 more in payments in the CDJ files when compared to the verification files. The potential missing interest payments in the verification data may be the result of a reporting error when generating the verification data, and may not represent actual over-reported payments in the CDJ file.*

Vision Claims – Avesis Vision

Avesis Vision submitted check register details and weekly Automated Clearinghouse (ACH) summaries for January 2021 as their verification documentation. We compared the weekly payments to the summarized CDJ files in *Table 10* below.

Table 10: Avesis Vision CDJ to Verification Documentation Comparison

Avesis Vision CDJ to Verification Documentation Comparison					
Verification Documentation		**January 2021 CDJ Submissions**		**Comparison**	
Check Date	**Paid Amount**	**Transaction Date**	**Transaction Amount**	**Variance**	**Verification Percentage**
1/6/2021	$84,686	1/6/2021	$84,699	-$13	100.0%
1/13/2021	$85,492	1/13/2021	$85,809	-$317	100.4%
1/20/2021	$99,364	1/20/2021	$99,406	-$42	100.0%
1/27/2021	$86,716	1/27/2021	$86,744	-$28	100.0%
TOTAL	**$356,259**		**$356,658**	**-$399**	**100.1%**

Overall, the verification data included approximately $399 more in payments when compared to the CDJ files, representing a potential under-reporting of payments in the CDJ. This discrepancy is potentially related to adjustment sequences.

Pharmaceutical Claims – CVS/Caremark

CVS/Caremark submitted check register details and AGP submitted monthly claim invoice summaries for January 2021 as verification documentation. We compared daily summary payments to the summarized CDJ files. In general, the transaction date reported in the CDJ files appeared to occur one day after the check register disbursement date in the verification document. As a result, we compared daily summaries from the verification document to CDJ summaries for the following day for the most representative comparison in *Table 3*.

Table 3: CVS/Caremark CDJ to Verification Documentation Comparison

CVS/Caremark CDJ to Verification Documentation Comparison					
Verification Documentation		January 2021 CDJ Submissions		Comparison	
Disbursement Date	Paid Amount	Transaction Date	Transaction Amount	Variance	Verification Percentage
12/31/2020	$199,097	1/1/2021	$199,097	$0	100.0%
1/1/2021	$31,052	1/2/2021	$31,052	$0	100.0%
1/2/2021	$45,997	1/3/2021	$45,997	$0	100.0%
1/3/2021	$47,471	1/4/2021	$47,471	$0	100.0%
1/4/2021	$146,292	1/5/2021	$146,292	$0	100.0%
1/5/2021	$188,130	1/6/2021	$2,063,898	-$1,875,769	1097.1%
1/6/2021	$2,019,372	1/7/2021	$143,603	$1,875,769	7.1%
1/7/2021	$90,760	1/8/2021	$90,760	$0	100.0%
1/8/2021	$97,780	1/9/2021	$97,780	$0	100.0%
1/9/2021	-$10,817	1/10/2021	-$10,817	$0	100.0%
1/10/2021	$47,510	1/11/2021	$47,510	$0	100.0%
1/11/2021	$161,984	1/12/2021	$161,984	$0	100.0%
1/12/2021	$185,594	1/13/2021	$1,805,380	-$1,619,786	972.8%
1/13/2021	$1,760,369	1/14/2021	$140,583	$1,619,786	8.0%
1/14/2021	$171,506	1/15/2021	$171,506	$0	100.0%
1/15/2021	$226,974	1/16/2021	$226,974	$0	100.0%
1/16/2021	$33,469	1/17/2021	$33,469	$0	100.0%
1/17/2021	$35,583	1/18/2021	$35,583	$0	100.0%
1/18/2021	$92,808	1/19/2021	$92,808	$0	100.0%
1/19/2021	$166,638	1/20/2021	$2,169,763	-$2,003,124	1302.1%
1/20/2021	$2,139,721	1/21/2021	$136,597	$2,003,124	6.4%
1/21/2021	$102,382	1/22/2021	$102,382	$0	100.0%
1/22/2021	$123,889	1/23/2021	$123,889	$0	100.0%
1/23/2021	$9,283	1/24/2021	$9,283	$0	100.0%
1/24/2021	$36,928	1/25/2021	$36,928	$0	100.0%
1/25/2021	$210,086	1/26/2021	$210,086	$0	100.0%
1/26/2021	$211,999	1/27/2021	$2,245,160	-$2,033,162	1059.0%
1/27/2021	$2,160,567	1/28/2021	$127,405	$2,033,162	5.9%
1/28/2021	$135,191	1/29/2021	$135,191	$0	100.0%
1/29/2021	$112,031	1/30/2021	$112,031	$0	100.0%

CVS/Caremark CDJ to Verification Documentation Comparison					
Verification Documentation		**January 2021 CDJ Submissions**		**Comparison**	
Disbursement Date	**Paid Amount**	**Transaction Date**	**Transaction Amount**	**Variance**	**Verification Percentage**
1/30/2021	$27,142	1/31/2021	$27,142	$0	100.0%
TOTAL	**$11,006,787**		**$11,006,787**	**$0**	**100.0%**

We also compared the total CDJ summary amount for transactions made in January 2021 ($11,006,787) to the AGP-supplied monthly claims invoice amount for claim paid in January 2021 ($11,006,772). The observed variance was approximately -$15, and the estimated verification percentage based on the invoiced claim summary was approximately 100.0 percent.

Findings and Recommendations

Table 4 below summarizes the findings and recommendations identified during this engagement are based on the data and documentation provided by AGP and the information obtained during virtual interviews.

Table 4: Findings and Recommendations

Findings and Recommendations			
Entity	**Functional Area**	**Findings**	**Recommendation**
AGP	**Call Center Operations**	During a live member call demonstration, a member call center agent was unable to provide assistance to a member who wanted to change their CMO.	AGP should ensure all call center staff are trained on how to properly instruct members on making a CMO change.
AGP	**CDJ Submissions**	Myers and Stauffer observed instances of potential under-reported and potential over-reported payments in AGP's and its subcontractor's CDJ submissions.	AGP should develop financial reconciliation processes to continuously monitor the completeness and accuracy of its CDJ files submissions against independent financial sources.
AGP	**Encounter Submissions**	Myers and Stauffer found that Anthem is not performing oversight of IngenioRx pharmacy encounters. The only oversight being performed is a comparison of CDJs to encounters for completeness.	AGP should create audit steps to ensure the accuracy of IngenioRx encounters.
AGP	**Encounters Submissions**	AGP stated that there were no specific procedures to check for duplicates found in EDIFECS.	AGP should revise their existing quality check procedures to ensure they include steps to verify duplicates found in EDIFECS.
AGP	**Encounter Submissions**	Myers and Stauffer observed potentially missing encounters in the MMIS, for example: paid and denied Avesis Vision encounters, paid and denied AGP FFS encounters, and paid DentaQuest encounters.	AGP and its subcontractors should review processes and policies for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim lines.

Findings and Recommendations			
Entity	**Functional Area**	**Findings**	**Recommendation**
AGP	**Encounter Submissions**	Myers and Stauffer observed mismatching claim data elements between the AGP FFS claims, subcontractor encounters extracts, and the MMIS encounters.	AGP and its subcontractors should review their processes and policies for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim data elements.
AGP	**Georgia Families 360 – Care Coordination**	Myers and Stauffer found that there is potential risk of AGP not being able to outreach and provide adequate assistance to all members due to the number of members assigned to a care coordinator.	AGP should develop and implement a plan to address the ratio of members to care coordinators. We recommend hiring new care coordinators or develop on sub coordinator staff to fill in gaps in outreach or assistance to members.
AGP	**Member Data Maintenance**	Myers and Stauffer found that AGP does not send an outbound member file to DCH detailing the updates performed as a result of their internal member file review.	AGP should submit an outbound member file to DCH containing the results of their member review.
AGP	**Program Integrity**	Myers and Stauffer observed 63 fraud, waste and abuse cases were closed or suspended in state fiscal year 2021, noting a DCH COVID stand down order. This appears to have been associated with the dramatic reduction in SIU case backlog occurring during February and March 2021.	AGP should review all fraud, waste and abuse cases closed during the DCH COVID stand down period to assess the need to resume some of these cases. Furthermore, AGP should increase data mining of encounters that occurred during calendar years 2020 and 2021 to search for fraud and abuse that may have been missed due to the DCH COVID stand down orders.
AGP	**Provider Data Maintenance**	Virtual interview responses indicated that the contracting team is not fully reviewing and utilizing the network adequacy deficiency reports.	AGP should enhance their review of network adequacy deficiency reports in order to maximize their recruiting efforts and potentially achieve improved results.
AGP	**Subcontractor Oversight**	Virtual interview responses indicated that AGP is not auditing or validating the data found in the oversight reports that they receive from subcontractors.	AGP should develop procedures to include steps to review the subcontractor oversight reports to ensure the subcontractors are meeting performance guarantees.
CVS	**Claims and Encounter Systems Demonstrations**	CVS/Caremark did not provide a demonstration of their claims pricing processes and procedures.	AGP should communicate the importance of the Myers and Stauffer engagement and strongly request CVS/Caremark's full participation in the audits up to and including a demonstration or a detailed overview.

Findings and Recommendations			
Entity	**Functional Area**	**Findings**	**Recommendation**
CVS	**Claims and Encounter Systems Demonstrations**	While interviewing with CVS/Caremark, we were denied a demonstration and request to review their encounter submission system or dashboard, stating "proprietary" reasons.	AGP should communicate the importance of the Myers and Stauffer engagement and strongly request CVS/Caremark's full participation in the audits up to and including a demonstration or a detailed overview.
CVS	**Encounter Submissions**	Myers and Stauffer observed potentially missing paid and denied CVS/Caremark encounters in the MMIS.	CVS/Caremark should review processes and policies for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim lines.
CVS	**Encounter Submissions**	Myers and Stauffer observed mismatching claim data elements between the CVS/Caremark extracts and the MMIS encounters.	CVS/Caremark should review their processes and policies for the reporting of encounters to the MMIS and adjust their processes to ensure reliable reporting of claim data elements.
DentaQuest	**Encounter Submissions**	Myers and Stauffer found that there is potential for missing original claims in the encounters because in-cycle adjustments are not identified during the encounter submission process.	DentaQuest should revise the encounter submissions policies and procedures to an automated process for in-cycle adjustments reducing the risk of missing claims in the encounter data.
DentaQuest	**Third Party Liability and Coordination of Benefits**	Myers and Stauffer found that there is no method for payment recovery when a member has an insurance that is primary to Medicaid.	DentaQuest should consider the use of a cost avoidance in order to recoup monies paid for Medicaid members who had a primary insurance.

Exhibit I: Virtual Interview Schedules

Interviews with AGP

In order to gain a better understanding of AGP's policies and procedures for contract compliance, PI, encounter submissions, and subcontractor oversight, Myers and Stauffer interviewed the individuals listed in *Table 5* below on the dates and at the locations indicated.

Table 5: AGP Interviews

Date	Interviewees	Title
11/1/2021	Leticia Mayfield	Compliance Director
11/1/2021	Lisa Ridley	Compliance Analyst
11/1/2021	Heather Dyke	Compliance Manager
11/1/2021	Jennifer Mace	Manager Compliance
11/1/2021	Maria Henriquez	Director Medicaid Health Plan Marketing
11/1/2021	Joyce LeTourneau	Manager II Enrollment Data
11/1/2021	Tricia Jones	Nurse Appeals Senior
11/1/2021	Markeshia Jones	Grievance and Appeals Analyst Senior
11/1/2021	Tracy Kristalakis	Behavioral Health Care Manager III
11/1/2021	Pamela Gilmore	Behavioral Health Case Manager Lead
11/1/2021	Andre'a Brown	Clinical Quality Program Manager
11/1/2021	Heather Taylor	Clinical Quality Program Administrator
11/1/2021	Debra Robinson	Director GBD Special Programs Services
11/1/2021	Heather Macgregor	Quality Evaluator Senior
11/1/2021	Ebrima Janneh	Manager I; Medical Management
11/1/2021	Dana Wheeler	Manager I; Medical Management
11/2/2021	Felicia Bryant	Manager; Customer Care/GBD Provider Services
11/2/2021	Valerie Hawkins-Smith	Customer Care Representative II
11/2/2021	Annesheia Boxley-Jones	Manager Customer Care (GF360°)
11/2/2021	Joyce LeTourneau	Enrollment Data Manager
11/2/2021	Garnett Greene	Customer Care Representative II
11/2/2021	Abigail Boldin	Ombudsman Liaison
11/2/2021	Sherry Sanders	Provider Experience Manager
11/2/2021	Matthew Ellis	Provider Experience Consultant
11/2/2021	Deborah Moore	Network Relations Consultant Senior
11/2/2021	Shamika Malone	Provider Network Manager Senior
11/2/2021	Monique Crawford	Business Change Manager Senior
11/2/2021	Michelle Bednarczyk	Director Program/Project Management
11/2/2021	Shakia Williams	Compliance Manager/IngenioRx

Date	Interviewees	Title
11/2/2021	Cassandra Tancil	Pharmacist Program Manager
11/2/2021	Vivian Scott	Director II Provider Experience
11/2/2021	Monica Lester	Director Network Management (Contracting)
11/3/2021	Siyama Drake	Program Director
11/3/2021	Tanya Chambers	Manager GBD Special Programs
11/3/2021	Wanda Burns-Jackson	Case Manager
11/3/2021	Ashleigh Cream	Case Manager
11/3/2021	Joyce LeTourneu	Enrollment Data Manager
11/3/2021	Geneva Massenburg	Enrollment Data Analyst
11/3/2021	Gretchen Vilhauer	Manager; Financial Ops
11/3/2021	Deborah Moore	Network Relations Consultant Senior
11/3/2021	Shamika Malone	Provider Network Manager Senior
11/3/2021	Siyama Drake	Program Director
11/8/2021	Kim Wright	Regulatory Compliance Consult/SIU Fraud and Abuse
11/8/2021	Carrie Godby	Manager I/Investigations
11/8/2021	Cassandra Henrichs	Vendor Implementation Manager
11/8/2021	Shakia Wiliams	Compliance Manager
11/8/2021	Cassandra Tancil	Pharmacist Program Management
11/8/2021	Joyce LeTourneau	Manager II Enrollment Data
11/8/2021	Amy Spaugh	Business Systems Implementation Manager
11/8/2021	Jamie Giron	Business Consultant
11/8/2021	Gretchen Vilhauer	Financial Operations Manager
11/8/2021	Kerensa Salvietti	Director Program Management
11/8/2021	Marquette Moore	Business Information Consultant
11/8/2021	Christopher Kearney	Director HP Operations
11/8/2021	Gina Bingham	Process Improvement Manager
11/8/2021	Nancy Sare	Business Change Manager; Senior; COB
11/8/2021	Kearsten Lewis	Program Manager
11/8/2021	Mary Deadwiler	Manager Strategies; Financial Operations Department
11/8/2021	Ronda Holmes	Program Integrity Manager
11/8/2021	Twanya Cooper	Claims Manager I
11/9/2021	Erik Vazqetelles	Senior Director Engineering
11/9/2021	Robin Favret	Not provided
11/9/2021	Victor Martin	Enterprise EDI Support
11/9/2021	John Kuehn	VLM Support
11/9/2021	Twanya Cooper	Claims Manager I
11/9/2021	Connie Melton	Manager II Claims
11/9/2021	Kimberly Kenyatta	Process Expert Senior
11/9/2021	Connie Melton	Manager II; Claims

Date	Interviewees	Title
11/9/2021	Aleh Bul	Business Architect Senior
11/9/2021	Tanner Hodges	Director; Reporting and Data Analysis (Encounters Operations)
11/9/2021	Pankaj Saraswat	Manager Business Information; Encounters Batch Submission
11/10/2021	Erik Vazquetelles	Senior Director of Engineering
11/10/2021	Robin Favret	IT Strategy and Planning Director
11/10/2021	Sara Bahoura	IT Account Management Senior Advisor
11/10/2021	Heather Dyke	Compliance Manager
11/10/2021	Beth Mull	Reporting COE
11/10/2021	William Harris	System Analyst
11/10/2021	Marquette Moore	Business Information Consultant
11/10/2021	Heather Taylor	Clinical Quality Program Administration
11/10/2021	Angela Evens	Program Consultant
11/10/2021	Dorothy DeLosSantos	Business Change Director
11/10/2021	Benjamin McCarthy	Business Information Consultant
11/10/2021	Sheila Nelson	Business Information Development
11/10/2021	Latisha Adams	Manager Business Information
11/10/2021	Cody Stuz	Manager Program Management
11/10/2021	Roger Balducci	RVP Government Finance
11/10/2021	James Harris	Director I Technology
11/10/2021	Manuel Gonzalez III	Business Information Consultant
11/10/2021	Cassandra Hendrichs	Vendor Implementation Manager
11/10/2021	Murphy Duckett	Not provided
11/10/2021	Scott Padget	Director Network Management
11/10/2021	Anar Pathak	Director of Sourcing
11/10/2021	Bobbi Hansford	Director of Financial Operations
11/10/2021	Moji Esho	Actuarial Director
11/10/2021	Katarina Hemenway	Actuarial Analyst II

Interviews with Subcontractors

One Source

One Source provides speech, occupational, and physical therapy prior authorization services for AGP members. The Myers and Stauffer engagement team met virtually with One Source staff on December 7, 2021. We interviewed the individuals listed in *Table 6* below.

Table 6: One Source Interviews

Date	Interviewees	Title
12/7/2021	Lorriane Sanchez	Vice President of Clinical Case Management/ Privacy Officer/FWA Coordinator/Compliance Office
12/7/2021	Dr. Oscar Benavides	Medical Director
12/7/2021	Jelline Camacho	Office Coordinator/ Claim Analyst
12/7/2021	Karen Nelson	Occupational Therapy Reviewer
12/7/2021	Lisa Reed	Occupational Therapy Reviewer
12/7/2021	Carol Siu	Senior Physical Therapy Reviewer
12/7/2021	Kelly Day	MS; CCC/SLP; Speech Therapy Reviewer

IngenioRx

IngenioRx provides specialty PBM services. Myers and Stauffer met virtually with IngenioRx staff on November 17 through 18, 2021. We interviewed the individuals listed in *Table 7* below.

Table 7: IngenioRx Interviews

Date	Interviewees	Title
11/17/2021	Shakia Williams	PBM Compliance Manager
11/17/2021	Christine Swick	Director II Compliance
11/17/2021	Yvette Lucy	Program Manager
11/17/2021	Cassandra Tancil	Pharmacist Program Manager
11/17/2021	Meredith Fleming	Pharmacy Network Management Director
11/17/2021	Raymond Warner	Director Pharmacy Management
11/17/2021	Marcie Young	Director Systems Support and Programs
11/17/2021	Vanessa Price	Process Expert Senior
11/17/2021	Deb Crawford	Director Clinical Pharmacy Strategies
11/17/2021	Ken Dumaine	IRx Member Experience
11/17/2021	Kia Morrison	IRx Member Experience
11/17/2021	Bianca Sessions	Pharmacist Clinical Pharmacy
11/17/2021	Tracy Harrell	Director Clinical Pharmacy Strategies
11/17/2021	Setifah Jordan	Pharmacist Clinical Senior
11/17/2021	Elaan Radley	Pharmacist Clinical
11/17/2021	Steve Broudy	Clinical Pharmacy Program Director
11/17/2021	Rod Granlund	Process Expert
11/17/2021	Tamara Reynolds	Director Pharmacy Operations Support
11/17/2021	Nick Cummings	PBM Pricing Strategy Analyst Manager
11/18/2021	Chanda Cromwell	Process Expert Senior

Date	Interviewees	Title
11/18/2021	Behnaz Esmailizadeh	Manager II Systems Support and Programs
11/18/2021	Reji Radhakrishnan	Director Pharmacy Portfolio
11/18/2021	Robert Timmers	Director Financial Accounting/ Reporting/ Analysis
11/18/2021	Marcie Young	Director Systems Support and Programs
11/18/2021	Vanessa Price	Process Expert Senior
11/18/2021	Cassandra Tancil	Pharmacist Program Manager
11/18/2021	Nicole Weickert-Bevis	Director Clinical Quality Management
11/18/2021	Essence Lee	Business Consultant
11/18/2021	Jermaine Gipson	Business Change Manager

DentaQuest

DentaQuest provides dental services to AGP members. Myers and Stauffer met virtually with DentaQuest on November 15 through 16, 2021. We interviewed the individuals listed in *Table 8*.

Table 8: DentaQuest Interviews

Date	Interviewees	Title
11/15/2021	Christina Medina	Managing Client Partner
11/15/2021	Javonya Harris	Client Partner
11/15/2021	Shiela Schmidt	Manager; Customer Service
11/15/2021	Stephanie Tate	Managing Provider Partner
11/15/2021	Troy Boothe	UM Auditing Coordinator
11/15/2021	Emily Knezic	UM Auditing Coordinator
11/15/2021	Nicholas Messuri	Vice President; Fraud Prevention and Recovery
11/15/2021	Kathlene Gruettner	Manager; Fraud Prevention and Recovery
11/15/2021	Jeanine M Rank	Operations Audit Coordinator II
11/16/2021	Kyesha Washington	Supervisor; Claim Processing
11/16/2021	Lorann Tenhaken	Operations Manager; Intake and Scanning
11/16/2021	Laura Rechcygl	Director; Claims Operations
11/16/2021	William Munns	Manager; Client and Member Data Management
11/16/2021	Lora Schneider	Technical Product Owner; Senior
11/16/2021	Laura Rechcygl	Director; Claims Operations
11/16/2021	Jaqueline Clouse	Provider Contracting Process
11/16/2021	Tom White	Provider Updates
11/16/2021	Michael Duhamel	Director Member Enrollment and Benefits
11/16/2021	Liza Filtz-Freimark	Manager; Provider Operations

CVS/Caremark

CVS/Caremark is AGP's PBM and provides pharmacy services to AGP members. Myers and Stauffer met virtually with CVS/Caremark staff on November 29, 2021. We interviewed the individuals listed in *Table 9*.

Table 9: CVS/Caremark Interviews

Date	Interviewees	Title
11/29/2021	Marty Mangin	Senior Director Adjudication Solutions
11/29/2021	Britta Berney	Director of Encounter Operations
11/29/2021	Jana Cruz	Manager of Finance
11/29/2021	Bethany Williams	Advisor
11/29/2021	Nadine Sanchez	PBM Revenue Cycle and Payment Operations Director
11/29/2021	James Brower	Senior Manager of PBM Financial Operations
11/29/2021	Nicholas Spetrino	Supervisor in Claims Processing
11/29/2021	Patricia Ponczkowski	Director of Claims Processing
11/29/2021	Mark Badillo	Senior Manager of Eligibility
11/29/2021	Victoria Zupancic	Director of IT Systems
11/29/2021	Shonda Leeper	Director of Client Operations
11/29/2021	Andrew Navik	Senior Manager of Analytic Services
11/29/2021	Steven Fox	Senior Advisor of Analytic Services

Avesis

Avesis provides vision services to AGP members. Myers and Stauffer met virtually with Avesis staff on December 15 through 16, 2021. We interviewed the individuals listed in *Table 10*.

Table 10: Avesis Interviews

Date	Interviewees	Title
12/15/2021	Crystal Cannon	Director; Eye Care Services
12/15/2021	Shawn Blair	Eye Care Program Integrity
12/15/2021	Sharon Kramer	Quality and Audit
12/15/2021	David McManus	Account Management
12/15/2021	Jeanine Saer	Director; Contact Center
12/15/2021	Diana Schneider	Manager; Contact Center
12/15/2021	Alicia Slater	Manager; Risk and Control
12/15/2021	Dr. David Worth	Director; Clinical
12/15/2021	Miriam Ramirez	Manager; Utilization Review
12/15/2021	Amy Springer	Team Lead; Audit

Date	Interviewees	Title
12/15/2021	Lauren Dillard	Supervisor; Appeals and Grievance
12/16/2021	Kathleen Allan	Director; Claims
12/16/2021	Adriana Hinojosa	Manager; Claims
12/16/2021	Ashley Meling	Operational Audit Lead
12/16/2021	Linda LaPointe	Manager Finance
12/16/2021	Sharon Kramer	Director Quality and Audit
12/16/2021	Lori Peterson	Director New Business Services
12/16/2021	Walter Pawlak	Director; Provider Relations
12/16/2021	Marian Guiterrez	Manager; Network Provider Information
12/16/2021	Alicia Slater	Manager; External Audit
12/16/2021	Vanessa Verlinger	Supervisor; New Business Services
12/16/2021	Stephanie Singer	Eligibility Lead
12/16/2021	Vasanth Rajendran	Technical Manager; III
12/16/2021	Elizabeth Dexter	Manager; Systems Administration

AIM Specialty

AIM Specialty provides radiology and diagnostic UM for imaging services to AGP members. The Myers and Stauffer engagement team met virtually with AIM Specialty staff on December 8, 2021. We interviewed the individuals listed in *Table 11*.

Table 11: AIM Specialty Interviews

Date	Interviewees	Title
12/8/2021	Maureen Prendergast	Director II Compliance Performance Management
12/8/2021	Kathy Patrick	Director II; Compliance
12/8/2021	Shrese Williams	Manager I; Medical Management
12/8/2021	Max Zaychik	Not provided
12/8/2021	Dr. Curtis Witcher	Clinical Operations Medical Director Physician Reviewer
12/8/2021	Anna Vu	Nurse Reviewer II
12/8/2021	Julie Choe	Nurse Reviewer; Senior
12/8/2021	Stephanie Smith	Team Lead
12/8/2021	Miguel Hernandez	Manager I

Exhibit II: Supporting Detail for Encounter Submissions and Payment Systems

Myers and Stauffer requested specific claim data elements to be included in the claim and encounter data samples submitted by the subcontractors for this review. Claim elements requested varied by claim type (e.g., tooth number codes were only assessed for dental claims). For all claims and encounters found to exist in both the data samples and the MMIS encounters, Myers and Stauffer measured the percentage of such claims where the data element value in the data samples exactly matched the value in the MMIS encounters. Results of the comparison were presented in five tables, broken out by subcontractor and claim type as:

- *AGP Health Plan.*
  - *Table 1 – Institutional (837I/UB04).*
  - *Table 2 – Professional (837P/CMS-1500).*
- *DentaQuest Dental.*
  - *Table 3 – Dental (837D/ADA).*
- *Avesis Vision.*
  - *Table 4 – Vision (837P/CMS-1500).*
- *CVS/Caremark.*
  - *Table 5 – Pharmaceutical (NCPDP).*

The following tables include a listing of all claim data elements assessed for each adjudicating entity and claim type. For each data element, there is a percentage indicating the portion of CMO or subcontractor's claims having values matching the value in their MMIS encounters.

Percentages greater than or equal to 99.95 percent and less than 100 percent were truncated to 99.9 percent. Percentages below 99 percent were reviewed more in-depth. Observations and findings were included for some scenarios of missing or mismatching data values between the CMO and subcontractor claims and MMIS encounters.

Exhibit II, Table 1: Amerigroup Institutional Claims

Amerigroup FFS – Institutional (837I / UB04) Claim Lines Reviewed = 539,400			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.0	The claim receipt date reported in the AGP FFS extracts for institutional claim lines did not match the claim receipt date reported in the MMIS encounters. In most cases (99.8%), the claim receipt date reported in the MMIS encounters may represent the date AGP paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	99.9	
3	Amount Paid – Claim Header	99.9	
4	Amount Paid – Claim Detail Lines	98.9	For approximately 4,600 institutional claim lines (0.9%) the detail line paid amount reported in AGP institutional claim extracts did not match the value reported in the MMIS encounters, and the sum of the line paid amounts in the MMIS did not equal the header paid amount. Most of these claims were reported as $0 paid at the header in the MMIS encounters.
5	Interest Paid – Claim Header	96.4	Approximately 19,300 (3.6%) institutional encounter claim lines in the MMIS encounters appeared to be missing provider interest payments or interest was not separately identified in the MMIS encounters for these claim lines.
6	Denial Indicator – Claim Header	99.9	
7	Member Medicaid ID	99.7	
8	Payee Provider Tax ID	98.8	For approximately 5,700 institutional claim lines (1.1%) it appeared that the payee provider in the MMIS encounters for AGP was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	94.5	We observed approximately 20,000 institutional claim lines (5.4%) in the sample where the rendering provider NPI in the MMIS institutional encounters for AGP appeared to be an older NPI associated with the Medicaid provider ID on the claim. The NPI reported in the MMIS encounters may not be the most appropriate ID currently used by the rendering provider.
10	Referring Provider NPI	0.0	The referring provider NPI did not appear to be reported in the MMIS for AGP institutional encounters.

Amerigroup FFS – Institutional (837I / UB04) Claim Lines Reviewed = 539,400			
	Claim Data Element	**% Match**	**Notes**
11	Attending Provider NPI	23.6	The attending provider NPI supplied on approximately 411,900 institutional claim lines (76.4%) in the AGP claims extracts did not appear to be reported in the MMIS encounters.
12	Operating Provider NPI	95.3	Myers and Stauffer requested AGP include the operating provider NPI when preparing the claims extracts; however, it appeared the operating provider NPI was not included in the AGP claims extracts for approximately 25,500 institutional claim lines (4.7%). This field may not be required for submission to the MMIS.
13	DRG Code	99.2	
14	Claim ICD Diagnosis Codes	99.1	The majority of diagnosis codes billed on the inbound claims appeared to be reported in the MMIS encounters; however, the ordering of secondary diagnosis codes in the MMIS encounters may not always match the ordering of secondary diagnosis codes as reported on the inbound claim.
15	Claim ICD Surgical Procedure Codes	99.7	
16	Type of Bill	99.9	
17	Medical Record Number	99.5	
18	Amount Billed – Claim Header	99.2	
19	Amount Billed – Claim Detail Lines	97.4	Approximately 13,900 AGP institutional claim lines (2.6%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amounts in the AGP institutional extracts appeared to match the line billed amount reported in the MMIS encounters.
20	Admission Date	99.8	
21	Discharge Date	99.3	
22	First Date of Service – Claim Header	99.8	
23	Last Date of Service – Claim Header	98.4	For approximately 8,400 institutional claim lines (1.6%), it appeared the claim header last date of service in the AGP institutional claims extracts did not match the claim header last date of service reported in the MMIS encounters. For most of these claim lines, the header last date of service reported in the MMIS encounters did not agree with the latest line date of service on the claim. For these claim lines, the header last date of service reported in the MMIS encounters may have been derived from claim discharge date and may not always accurately represent the claim last date of service.
24	First Date of Service – Claim Detail Lines	99.9	

Amerigroup FFS – Institutional (837I / UB04) Claim Lines Reviewed = 539,400			
	Claim Data Element	**% Match**	**Notes**
25	Last Date of Service – Claim Detail Lines	99.9	
26	Claim Detail Line Number	92.0	Approximately 27,200 institutional claim lines (5.1%) appeared to have been reordered in the MMIS encounters. Furthermore, approximately 6,000 additional institutional claim lines (1.1%) appeared to have been bundled into fewer claim lines in the MMIS institutional encounters. As a result of potential claim line reordering and bundling, the line number on approximately 43,200 AGP institutional claim lines (8.0%) appeared to have been either renumbered or reordered in the MMIS encounters.
27	Units Billed	97.6	Approximately 9,200 AGP institutional claim lines (1.7%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed units in the AGP institutional extracts appeared to match the line billed units reported in the MMIS encounters.
28	Revenue Code	100.0	
29	Procedure Code	99.9	
30	Procedure Code Modifier 1	99.8	
31	Procedure Code Modifier 2	99.9	
32	Procedure Code Modifier 3	99.9	This data element appears to be largely not populated in the supplied claims extracts or in the MMIS encounters.
33	Procedure Code Modifier 4	N/A	This data element was not populated in the supplied claims extracts or in MMIS encounters.
34	NDC	99.3	

Exhibit II, Table 2: Amerigroup Professional Claims

Amerigroup FFS – Professional (837P / CMS-1500) Claim Lines Reviewed = 1,517,300			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Plan by Provider	0.1	The claim receipt date reported in the AGP FFS extracts for professional claim lines did not match the claim receipt date reported in the MMIS encounters. The claim receipt date reported in the MMIS encounters may represent the date AGP paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	100.0	
3	Amount Paid – Claim Header	99.9	
4	Amount Paid – Claim Detail Lines	98.6	For approximately 17,000 professional claim lines (1.1%), the detail line paid amount reported in AGP professional claim extracts did not match the value reported in the MMIS encounters, and the sum of the line paid amounts in the MMIS did not equal the header paid amount. Most of these claims were reported as $0 paid at the header in the MMIS encounters.
5	Interest Paid – Claim Header	97.0	Approximately 44,800 (3.0%) professional encounter claim lines in the MMIS encounters appeared to be missing provider interest payments, or interest was not separately identified in the MMIS encounters for these claim lines.
6	Denial Indicator – Claim Header	99.9	
7	Member Medicaid ID	99.7	
8	Payee Provider Tax ID	92.3	For approximately 113,800 professional claim lines (7.3%), it appeared that the payee provider in the MMIS encounters for AGP was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	98.8	We observed approximately 9,900 claim lines (0.6%) in the sample where the rendering provider NPI in the MMIS institutional encounters for AGP appeared to be an older NPI associated with the Medicaid provider ID on the claim. The NPI reported in the MMIS encounters may not be the most appropriate ID currently used by the rendering provider. In addition, 6,900 lines (0.4%) of the sampled claims did not appear to match.

Amerigroup FFS – Professional (837P / CMS-1500) Claim Lines Reviewed = 1,517,300			
	Claim Data Element	**% Match**	**Notes**
10	Referring Provider NPI	36.9	The referring provider NPI supplied on approximately 980,300 professional claim lines (63.1%) in the AGP claims extracts did not appear to be reported in the MMIS encounters. This field may not be required for submission to the MMIS.
11	Claim ICD Diagnosis Codes	99.6	
12	Amount Billed – Claim Header	99.8	
13	Amount Billed – Claim Detail Lines	98.9	Approximately 11,900 AGP professional claim lines (0.8%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amounts in the AGP professional extracts appeared to match the line billed amount reported in the MMIS encounters.
14	First Date of Service – Claim Header	99.9	
15	Last Date of Service – Claim Header	99.9	
16	First Date of Service – Claim Detail Lines	99.9	
17	Last Date of Service – Claim Detail Lines	99.9	
18	Claim Detail Line Number	96.7	Approximately 28,800 professional claim lines (1.9%) appeared to have been reordered in the MMIS encounters. Furthermore, approximately 7,900 additional professional claim lines (0.5%) appeared to have been bundled into fewer claim lines in the MMIS professional encounters. As a result of potential claim line reordering and bundling, the line number on approximately 50,700 AGP professional claim lines (3.3%) appeared to have been either renumbered or reordered in the MMIS encounters.
19	Units Billed	99.1	
20	Place of Service	99.9	
21	Procedure Code	99.9	
22	Procedure Code Modifier 1	99.1	
23	Procedure Code Modifier 2	99.4	
24	Procedure Code Modifier 3	99.9	
25	Procedure Code Modifier 4	99.9	This data element appears to be largely not populated in the supplied claims extracts or in the MMIS encounters.
26	NDC	99.9	

Amerigroup FFS – Professional (837P / CMS-1500) Claim Lines Reviewed = 1,517,300			
	Claim Data Element	**% Match**	**Notes**
27	Claim Detail Line ICD Diagnosis 1	92.6	We observed approximately 114,800 professional claim lines (7.4%) in AGP professional claims extracts whose claim detail line diagnosis code 1 did not match the value for their corresponding claim line in the MMIS professional encounters, this could be because the code was reordered or not present.
28	Claim Detail Line ICD Diagnosis 2	95.7	We observed approximately 64,600 professional claim lines (4.2%) in AGP professional claims extracts whose claim detail line diagnosis code 2 did not match the value for their corresponding claim line in the MMIS professional encounters, this could be because the code was reordered or not present.
29	Claim Detail Line ICD Diagnosis 3	97.2	We observed approximately 41,800 professional claim lines (2.7%) in AGP professional claims extracts whose claim detail line diagnosis code 3 did not match the value for their corresponding claim line in the MMIS professional encounters, this could be because the code was reordered or not present.
30	Claim Detail Line ICD Diagnosis 4	98.4	We observed approximately 23,200 professional claim lines (1.5%) in AGP professional claims extracts whose claim detail line diagnosis code 4 did not match the value for their corresponding claim line in the MMIS professional encounters, this could be because the code was reordered or not present.

Exhibit II, Table 3: DentaQuest Dental

DentaQuest Dental (837D / ADA) Claim Lines Reviewed = 412,000			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	99.9	
2	Date Paid	88.1	Myers and Stauffer requested DentaQuest include the paid date when preparing the claims extracts; however, it appeared the paid date was not included in the DentaQuest claims extracts for approximately 49,000 dental claim lines (11.9%).
3	Subcontractor Amount Paid – Claim Header	99.9	
4	Subcontractor Amount Paid – Claim Detail Lines	99.2	
5	Interest Paid – Claim Header	N/A	Interest did not appear to be present in the claims extract or in MMIS encounter data.
6	Denial Indicator – Claim Header	97.6	For approximately 9,900 DentaQuest dental claim lines (2.4%) the claim adjudication status reported in the claims extracts did not appear to match the claim status reported in the MMIS encounters. The majority of these claim lines were reported as $0 paid in the claims extracts and reported as denied in the MMIS encounters.
7	Member Medicaid ID	99.9	
8	Payee Provider Tax ID	93.3	For approximately 24,900 dental claim lines (6.0%), it appeared that the payee provider in the MMIS encounters for DentaQuest was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	99.5	
10	Referring Provider NPI	N/A	The referring provider NPI does not appear to be present in the claims extract or in the MMIS encounter data.
11	Claim ICD Diagnosis Codes	N/A	ICD diagnosis codes do not appear to be present in the claims extract or in the MMIS encounter data. This field may not be required for dental claims.
12	Amount Billed – Claim Header	99.9	
13	Amount Billed – Claim Detail Lines	96.3	Approximately 12,600 DentaQuest dental claim lines (3.0%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amounts in the DentaQuest extracts appeared to match the line billed amount reported in the MMIS encounters.
14	First Date of Service – Claim Header	99.8	
15	Last Date of Service – Claim Header	99.9	

DentaQuest Dental (837D / ADA) Claim Lines Reviewed = 412,000			
	Claim Data Element	**% Match**	**Notes**
16	First Date of Service – Claim Detail Lines	99.9	
17	Last Date of Service – Claim Detail Lines	99.9	
18	Claim Detail Line Number	95.7	Approximately 7,800 DentaQuest dental claim lines (1.9%) appeared to have been bundled into fewer claim lines in the MMIS encounters. Furthermore, approximately 4,600 additional dental claim lines (1.1%) appeared to have been reordered in the MMIS encounters. As a result of potential claim line bundling and reordering, the line number on approximately 17,900 DentaQuest dental claim lines (4.3%) appeared to have been either renumbered or reordered in the MMIS encounters.
19	Units Billed	100.0	
20	Place of Service	64.9	Myers and Stauffer requested DentaQuest include the place of service code when preparing the claims extracts; however, it appeared the place of service code was not included for approximately 144,600 dental claim lines (35.1%).
21	Procedure Code	98.4	For approximately 6,500 DentaQuest dental claim lines (1.3%) the procedure code appeared to have been changed from the value submitted on the inbound claim when the claims were submitted to the MMIS encounters. For most of these claim lines the procedure code submitted to the MMIS was reported as “D0210” (Intraoral – complete series of radiographic images).
22	Procedure Code Modifier 1	N/A	Procedure code modifiers did not appear to be populated in the supplied claims extracts or in MMIS encounters for dental claims.
23	Procedure Code Modifier 2	N/A	
24	Procedure Code Modifier 3	N/A	
25	Procedure Code Modifier 4	N/A	
26	Tooth Number	95.1	For approximately 19,900 DentaQuest dental claim lines (4.8%), the tooth number appeared to be missing in the MMIS encounters.
27	Tooth Surface Code 1	97.4	For approximately 10,700 DentaQuest dental claim lines (2.6%), the tooth surface code 1 appeared to be missing in the MMIS encounters.
28	Tooth Surface Code 2	99.9	
29	Tooth Surface Code 3	99.9	
30	Tooth Surface Code 4	99.9	
31	Tooth Surface Code 5	99.9	
32	Claim Detail Line ICD Diagnosis 1	N/A	ICD diagnosis codes do not appear to be present in the claims extract or in the MMIS encounter data. This field may not be required for dental claims.
33	Claim Detail Line ICD Diagnosis 2	N/A	
34	Claim Detail Line ICD Diagnosis 3	N/A	

DentaQuest Dental (837D / ADA) Claim Lines Reviewed = 412,000			
	Claim Data Element	**% Match**	**Notes**
35	Claim Detail Line ICD Diagnosis 4	N/A	

Exhibit II, Table 4: Avesis Vision

Avesis Vision (837P / CMS-1500) Claim Lines Reviewed = 27,500			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	2.2	The claim receipt date reported in the Avesis Vision extracts for vision claim lines did not match the claim receipt date reported in the MMIS encounters. The claim receipt date reported in the MMIS encounters may represent the date Avesis Vision paid the claim, since the claim receipt date appears to be the same date as the encounter paid date.
2	Date Paid	97.6	Myers and Stauffer requested Avesis Vision include the paid date when preparing the claims extracts; however, it appeared the paid date was not included in the Avesis Vision claims extracts for approximately 640 vision claim lines (2.4%).
3	Subcontractor Amount Paid – Claim Header	98.8	For approximately 320 Avesis Vision claim lines (1.2%), the header paid amount reported in the claims extracts did not appear to match the claim header paid amount reported in the MMIS encounters. Most of the observed discrepancies appeared to be due to reporting of interest, claim adjustment activity, or header amounts not matching to the sum of line amounts.
4	Subcontractor Amount Paid – Claim Detail Lines	99.2	
5	Interest Paid – Claim Header	0.0	Interest did not appear to be reported in the MMIS encounters for vision claims.
6	Denial Indicator – Claim Header	99.7	
7	Member Medicaid ID	99.9	
8	Payee Provider Tax ID	94.1	For approximately 1,400 vision claim lines (5.1%), it appeared the Payee Provider Tax ID in the MMIS encounters for Avesis Vision was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
9	Rendering Provider NPI	99.3	
10	Referring Provider NPI	99.6	
11	Claim ICD Diagnosis Codes	99.2	
12	Amount Billed – Claim Header	99.3	
13	Amount Billed – Claim Detail Lines	98.4	Approximately 350 Avesis Vision claim lines (1.3%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed amount in the Avesis Vision extracts appeared to match the line billed amount reported in the MMIS encounters.
14	First Date of Service – Claim Header	99.9	
15	Last Date of Service – Claim Header	99.9	

Avesis Vision (837P / CMS-1500) Claim Lines Reviewed = 27,500			
	Claim Data Element	**% Match**	**Notes**
16	First Date of Service – Claim Detail Lines	100.0	
17	Last Date of Service – Claim Detail Lines	100.0	
18	Claim Detail Line Number	96.2	Approximately 700 Avesis Vision claim lines (2.6%) appeared to have been bundled into fewer claim lines in the MMIS encounters. As a result of potential claim line bundling, the line number on approximately 1,000 Avesis Vision claim lines (3.8%) appeared to have been either renumbered or reordered in the MMIS encounters.
19	Units Billed	98.5	Approximately 350 Avesis Vision claim lines (1.3%) appeared to have been bundled into fewer claim lines in the MMIS encounters. The sum of bundled line billed units in the Avesis Vision extracts appeared to match the line billed units reported in the MMIS encounters.
20	Place of Service	97.5	The place of service code appeared to be hard-coded to the value "11" for all AGP Avesis Vision encounter claims in the MMIS encounters, and may not be an accurate representation of the place of service. The values reported in the MMIS encounters did not appear to match for approximately 670 (2.5%) of sampled claim lines.
21	Procedure Code	99.8	
22	Procedure Code Modifier 1	99.9	
23	Procedure Code Modifier 2	99.9	
24	Procedure Code Modifier 3	N/A	This data element was not populated in the supplied claims extracts or in MMIS encounters.
25	Procedure Code Modifier 4	N/A	This data element was not populated in the supplied claims extracts or in MMIS encounters.
26	NDC	99.9	
27	Claim Detail Line ICD Diagnosis 1	96.7	Line diagnosis code pointers for Avesis Vision claims in the MMIS encounters appear to be hard-coded to values "1," "1, 2," or "1, 2, 3;" line diagnosis codes reported in the MMIS encounters may not accurately represent the line diagnosis codes billed on the claim.
28	Claim Detail Line ICD Diagnosis 2	88.0	
29	Claim Detail Line ICD Diagnosis 3	97.2	
30	Claim Detail Line ICD Diagnosis 4	100.0	

Exhibit II, Table 5: CVS/Caremark

CVS/Caremark (NCPDP) Claim Lines Reviewed = 428,100			
	Claim Data Element	**% Match**	**Notes**
1	Date Submitted to Subcontractor by Provider	97.5	Pharmacy provider submission dates appear inaccurate for approximately 10,600 lines (2.5%) of the records. In these cases, the submission dates appear to occur after the date CVS/Caremark's system received the claims.
2	Date Paid	99.8	
3	Subcontractor Amount Paid	99.0	
4	Denial Indicator	99.0	
5	Member Medicaid ID	99.9	
6	Payee Provider Tax ID	93.7	For approximately 26,900 pharmacy claim lines (6.3%) it appeared the Payee Provider Tax ID in the MMIS encounters for CVS/Caremark was derived from the rendering provider. The payee provider in the MMIS may not accurately reflect the claim payee/billing provider reported on the claim submission.
7	Dispensing Provider NPI	98.7	We observed approximately 5,400 pharmacy claim lines (1.3%) in the sample where the dispensing provider NPI in the MMIS encounters for CVS/Caremark appeared to be an older NPI associated with the Medicaid provider ID on the claim. The NPI reported in the MMIS encounters may not be the most appropriate ID currently used by the dispensing provider.
8	Prescribing Provider	99.9	
9	Claim ICD Diagnosis Codes	N/A	ICD diagnosis codes do not appear to be present in the claims extract or in the MMIS encounter data. This field may not be required for pharmacy claims.
10	Prescription Number	100.0	
11	Amount Billed	2.6	The claim billed amount reported in the MMIS encounters for CVS/Caremark pharmacy encounters did not match the billed amount reported in the CVS/Caremark extracts. The billed amount reported in the MMIS encounters appeared to match the claim paid amount.
12	Date Filled	100.0	
13	Dispensed Units	99.9	
14	NDC	99.9	
15	Days' Supply	99.8	
16	Refill Number	100.0	

Appendix A: Glossary

- ***837 Healthcare Claim Transaction*** *– An electronic transaction designed to submit one or more encounters from the CMO to the FAC.*
- ***AIM Specialty Health (AIM or AIM Specialty)*** *– An AGP subcontractor that manages Diagnostic Imaging Utilization Management (UM) and as Consultation Management (CM) Call Center.*
- ***Amerigroup Community Care-GA (Amerigroup or AGP)*** *– An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids members. CMOs receive a per capita or capitation payment from the Department for each enrolled member.*
- ***Appeal*** *– A request for review of an action, as "action" is defined in 42 Code of Federal Regulations (CFR) §438.400.*
- ***Appeal Process*** *– The overall process that includes appeals at the contractor level and access to the State Fair Hearing process (the State's administrative law hearing).*
- ***Avesis*** *– Avesis is an AGP subcontractor that manages the vision services program.*
- ***Behavioral Health*** *– The discipline or treatment focused on the care and oversight of individuals with mental disorders and/or substance abuse disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders-Five published by the American Psychiatric Association. Those meeting the medical necessity requirements for services in behavioral health usually have symptoms, behaviors, and/or skill deficits which impede their functional abilities and affect their quality of life.*
- ***Behavioral Health Home*** *– A behavioral health home is responsible for the integration and coordination of the individual's health care (physical as well as behavioral health care services). Behavioral health home providers do not need to provide all the services themselves, but must ensure the full array of primary and behavioral health care services is available, integrated, and coordinated.*
- ***Behavioral Health Services*** *– Covered services for the treatment of mental, emotional, or chemical dependency disorders.*
- ***Care Management Organization (CMO)*** *– An organization that has entered into a risk-based contractual arrangement with the Department to obtain and finance care for enrolled Medicaid and PeachCare for Kids members. CMOs receive a per capita or capitation claim payment from the Department for each enrolled member.*

- ***Cash Disbursement Journal (CDJ)*** *– A listing of individual cash payments made to providers by a CMO or subcontractor for a given period. Cash, in this case, refers to amounts paid via cash, check, or electronic funds transfer.*
- ***Children's Health Insurance Program*** *– Provides health coverage to children in families with incomes too high to qualify for Medicaid, but cannot afford private coverage.*
- ***Claim*** *– An electronic or paper record submitted by a Medicaid provider to the CMO detailing the health care services provided to a patient for which the provider is requesting payment. A claim may contain multiple health care services.*
- ***Claim Adjudication*** *– The determination of the CMO's payment or financial responsibility, after the member's insurance benefits are applied to a claim.*
- ***Claims Processing System*** *– A computer system or set of systems that determine the reimbursement amount for services billed by the Medicaid provider and adjudicates claims according to the applicable coverage and payment policies.*
- ***Claims Universe*** *– The population parameters for claims to be tested, including the type of claim, the categories of service, and paid dates.*
- ***Clean Claim*** *– A claim received by the CMO for adjudication, in a nationally-accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the CMO.*
- ***Contract Compliance*** *– A form of contract management that seeks to ensure contractors are not in violation of the terms to which they have agreed.*
- ***Coordination of Benefits (COB)*** *– The practice of determining the order in which the health plans will pay when an individual is covered under multiple plans.*
- ***Credentialing Verification Organization (CVO)*** *– The entity contracted by DCH to determine the qualifications and ascribed privileges of providers to render specific health care services and make all decisions for whether a provider meets requirements to enroll in Medicaid and in Georgia Families.*
- ***CVS/Caremark*** *– CVS/Caremark is contracted by AGP to manage their pharmacy benefits program.*
- ***DentaQuest*** *– DentaQuest is contracted by AGP to manage their dental benefits program.*
- ***Department of Community Health (DCH or Department)*** *– The Department within the state of Georgia that oversees and administers the Medicaid and PeachCare for Kids programs.*
- ***Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit*** *– A comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21.*

- ***Encounter*** *– A distinct set of health care services provided to a member enrolled with a CMO on the dates that the services were delivered.*
- ***Encounter Claim (Encounter)*** *– A record of a health care service that was delivered to an eligible health plan member that is subsequently submitted by the CMO or the CMO's subcontractor to the Medicaid FAC to load and maintain in the Georgia Medicaid and PeachCare for Kids MMIS. The Medicaid FAC does not generate a payment for the encounter claim, but rather it is maintained for program management, rate setting, and a variety of program oversight functions.*
- ***Enrollment*** *– The process by which an individual eligible for Medicaid or PeachCare for Kids® applies (whether voluntary or mandatory) to utilize the Contractor's plan in lieu of the FFS program and such application is approved by DCH or its Agent.*
- ***Fee-for-Service (FFS) Medicaid*** *– For purposes of this engagement, FFS delivery is the portion of the Medicaid and PeachCare for Kids® program which provides benefits to eligible members who were not participants in the Georgia Families® program and where providers were paid for each service.*
- ***Fiscal Agent Contractor (FAC)*** *– The entity contracted with the Department to process Medicaid and PeachCare for Kids® claims and other non-claim specific payments, as well as to receive and store encounter claim data from each of the CMOs. Also sometimes referred to as the Fiscal Intermediary.*
- ***Fraud, Waste, and Abuse (FWA)*** *– Intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person (any act that constitutes fraud under applicable federal or state law); thoughtless or careless use, consumption, or spending of program resources; and improper use of program resources for personal gain or benefit.*
- ***Georgia Families*** *– The risk-based managed care delivery program for Medicaid and PeachCare for Kids® where the Department contracts with CMOs to manage and finance the care of eligible members.*
- ***Georgia Families 360°SM*** *– The risk-based Medicaid managed care delivery program for children, youth, and young adults in foster care, children and youth receiving adoption assistance, and certain youth involved in the juvenile justice system. AGP is the Care Management Organization managing this program.*
- ***Grievance*** *– An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.*

- ***Grievance System*** *– The overall system that addresses the manner in which the CMO handles grievances at the contractor level.*
- ***Health Insurance Portability and Accountability Act (HIPAA)*** *– The 1996 Act and its implementing regulations (45 CFR sections 142, 160, 162, and 164), all as may be amended.*
- ***Home-Based Services –*** *Services provided to Medicaid members with disabilities and/or chronic health conditions in the home setting.*
- ***IngenioRx*** *– IngenioRx is contracted by CVS/Caremark to manage certain specialty pharmacy benefits.*
- ***List of Excluded Individuals and Entities*** *– A list maintained by the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) comprising individuals and entities excluded from federally-funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act.*
- ***Medicaid Fraud Control Unit (MFCU)*** *– Investigates and prosecutes Medicaid provider fraud, as well as patient abuse or neglect in health care facilities and board and care facilities. The MFCUs, usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors; are constituted as single, identifiable entities; and must be separate and distinct from the state Medicaid agency.*
- ***Medicaid Management Information System (MMIS)*** *– Computerized system used for the processing, collecting, analyzing, and reporting of information needed to support Medicaid and PeachCare for Kids functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manuals.*
- ***Member*** *– An individual who is eligible for Medicaid or PeachCare for Kids benefits. An individual who is eligible for Medicaid or PeachCare for Kids benefits might also be eligible to participate in the Georgia Families program.*
- ***Member Call Center*** *– A toll-free number staffed by call center employees trained to accurately assist members with general inquiries, identify the need for crisis intervention and provide referrals to the appropriate resources in order to meet the Medicaid member's needs.*
- ***Member Disenrollment*** *– The process by which an individual seeks to terminate their Medicaid or PeachCare for Kids participation.*
- ***Member Enrollment*** *– The process by which an individual eligible for Medicaid or PeachCare for Kids applies to become a Medicaid recipient/participant.*
- ***National Provider Identifier (NPI)*** *– A unique 10-digit identification number required in administrative and financial transactions adopted under HIPAA for covered health care providers.*

- ***Ombudsman*** *– AGP employees responsible for coordinating services with local community organizations and working with local advocacy organizations to ensure members have access to covered and non-covered services; and collaborating with DCH to identify and resolve issues such as access to health care service.*
- ***One Source Therapy Review (One Source)*** *– One Source is an AGP subcontractor that manages utilization for physical therapy, speech therapy, and occupational therapy.*
- ***PeachCare for Kids®*** *– A comprehensive health care program for uninsured children living in Georgia. Premiums are required for children ages six and older.*
- ***Planning for Healthy Babies (P4HB)*** *– A DCH comprehensive prevention program to reduce the incidence of low birth weight infants.*
- ***Prescription Medication*** *– Medications prescribed for mental and substance use. There are many different types of medication for mental health problems, including anti-depressants, medication for attention issues, anti-anxiety medications, mood stabilizers, and antipsychotic medications.*
- ***Prior Authorization (PA)*** *– The process of reviewing a requested medical service or item to determine if it is medically necessary and covered under the member's plan.*
- ***Program Integrity (PI)*** *– Initiatives or efforts by the Department and the CMO to ensure compliance, efficiency, and accountability within the Georgia Families program. Efforts may include detecting and preventing FWA and ensuring Medicaid dollars are paid appropriately.*
- ***Prompt Pay Law*** *– Georgia's prompt pay law requires insurers to pay physicians within 15 days for electronic claims or 30 days for paper claims. If the insurer denies the claim, they must send a letter or electronic notice which addresses the reasons for failing to pay the claim.*
- ***Proposed Action*** *– The proposal of an action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the CMO to act within the timeframes provided in 42 CFR 438.408(b).*
- ***Provider*** *– Any person (including physicians or other health care professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the state of Georgia to provide health care services that has contracted with a CMO to provide health care services to members.*
- ***Provider Complaint*** *– A written expression by a provider which indicates dissatisfaction or dispute with the contractor's policies, procedures, or any aspect of a contractor's administrative functions.*
- ***Provider Network*** *– A provider network is a list of hospitals, physicians, and health care other that a CMO has contracted with to provide medical care to its members.*

- ***Provider Services –*** *The primary liaison between their organization and health care providers, such as medical doctors and dentists. Specific job duties vary, depending on the employer.*
- ***Quality and Performance Improvement*** *– Consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.*
- ***Required Assessments and Screenings*** *– Assessments and screenings used as tools to identify immediate needs for members transitioning into and out of Georgia Families 360°.*
- ***Special Investigations Unit (SIU)*** *– AGP/Anthem department responsible for the detection, prevention, investigation, reporting, correction, and deterrence of FWA.*
- ***State Fiscal Year (SFY)*** *– The fiscal period utilized by the state of Georgia that begins on July 1 of each year and ends on June 30 of the following year.*
- ***Subcontracted Services*** *– Medical services the CMO pays to be performed by another company that are outside the normal day-to-day operations of their company.*
- ***Subcontractor*** *– A vendor who is overseeing or administering the approval, payment, and administration of medical, dental, vision or other services to the Georgia Families population on behalf of a CMO.*
- ***Subcontractor Oversight*** *– Procedures to ensure subcontractors supply the services agreed to under the financial terms and programmatic requirements outlined. Good oversight holds subcontractors accountable while poor oversight may lead to waste, poor quality of care, fraud, and abuse of taxpayer dollars.*
- ***Third-Party Liability (TPL)*** *– TPL refers to the legal obligation of any other health insurance plan or carrier (i.e., individual, group, employer-related, self-insured, commercial carrier, automobile insurance, and/or worker's compensation) or program to pay all or part of the member's health care expenses.*
- ***U.S. Department of Health and Human Services – Office of Inspector General (HHS-OIG)*** *– The office of the federal government tasked with oversight of Medicare and Medicaid programs.*
- ***Utilization Management (UM)*** *– A service performed by the contractor which seeks to ensure covered services provided to members and P4HB participants are in accordance with, and appropriate under, the standards and requirements established by the contract, or a similar program developed, established, or administered by DCH.*
- ***Waiver Program*** *– Medicaid program(s) allowing health care professionals to provide care to members with disabilities and/or chronic health conditions in the home or community instead of a long-term care facility.*

- ***Waste*** *– Over-utilization of services or other practices that, directly or indirectly, result in unnecessary costs to the health care system, including the Medicare and Medicaid programs. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.*

Appendix B: Agreed-Upon Procedures

The AUPs described below will be applied to AGP and its subcontractors regarding contract compliance, claims management including encounter submissions, program integrity oversight, and subcontractor oversight as it relates to the Georgia Families and Georgia Families 360° programs.

- *We will request that AGP and its subcontractors identify and provide policies and procedures related to contract compliance in the following areas:*
  - *Behavioral Health.*
  - *Call Center Operations.*
  - *Internal Grievance/Appeal System.*
  - *Member Services.*
  - *Member Data Maintenance.*
  - *Monitoring and Reporting.*
  - *Pharmacy Services.*
  - *Provider Data Maintenance.*
  - *Provider Complaints.*
  - *Provider Network.*
  - *Provider Services.*
  - *Quality Management.*
  - *Third-Party Liability and Coordination of Benefits.*
  - *Utilization Management.*
- *The following procedures will be performed:*
  - *We will:*
    - *Review, then determine if the policies are in accordance with the contract between DCH and AGP.*
    - *Review the information provided during the AGP staff interviews, then determine if responses are in accordance with the contract between DCH and AGP.*

- *We will request that AGP and its subcontractors identify and provide their policies and procedures related to claims management including encounter submissions. We will also request claims data for analyses. The following procedures will be performed:*
    - *We will:*
        - *Review, then determine if the policies are in accordance with the contract between DCH and AGP.*
        - *Review the information provided during the AGP staff interviews then determine if responses are in accordance with the contract between DCH and AGP.*
        - *Analyze the claims workflows and processes within AGP and between AGP and its subcontractors.*
        - *Analyze the encounter workflows and processes within AGP and between AGP and its subcontractors.*
        - *Assess the effectiveness of internal controls used to ensure complete, timely, and accurate encounters are reported.*
        - *Select a sample of encounters submitted to the Department's FAC and trace the reported information to AGP's (and subcontractor's) payment system.*
        - *Research, then determine the cause of any discrepancies.*
        - *Analyze the claims payment system and accuracy of claim pay dates, particularly on adjustments and voids.*
- *We will request that AGP and its subcontractors identify and provide their policies and procedures related to program integrity oversight. The following procedures will be performed:*
    - *We will:*
        - *Review, then determine if the policies are in accordance with the contract between DCH and AGP.*
        - *Review the information provided during the AGP staff interviews, then determine if responses are in accordance with the contract between DCH and AGP.*
        - *Confirm that AGP's program integrity policies and procedures address prevention, detection, investigation, reporting, and corrective action of suspected cases of fraud, waste, and abuse (FWA).*
        - *Determine whether AGP has a monitoring system to address program integrity cases, along with methods and criteria for identifying, tracking, and resolving FWA cases.*

- *Ensure AGP has adopted and implemented training programs, which include FWA components.*
- *Review reports to confirm evidence of the AGP's oversight activities.*
- *Review AGP's organizational structure, including local and corporate staff. Determine whether they have dedicated local health plan staff performing oversight and monitoring activities.*

- *We will request that AGP identify and provide their policies and procedures related to subcontractor oversight. The following procedures will be performed:*
  - *We will:*
    - *Review, then determine if the policies are in accordance with the contract between DCH and AGP, and AGP and its subcontractors.*
    - *Review the information provided during the staff interviews, then determine if responses are in accordance with the contract between DCH and AGP, and AGP and its subcontractors.*
    - *Review AGP's approach to providing oversight of its subcontractors.*
    - *Analyze the claims workflows and processes within the subcontractors, and between the subcontractors and AGP.*
    - *Analyze the encounter workflows and processes within the subcontractors, and between the subcontractors and AGP.*
    - *Analyze the member and provider enrollment workflows and processes within the subcontractors, and between the subcontractors and AGP.*
    - *Analyze the member and provider data workflows and processes within the subcontractors, and between the subcontractors and AGP.*
    - *Determine whether the subcontractors have program integrity policies and procedures in place for the prevention, detection, investigation, reporting, and corrective action of suspected cases of FWA.*
    - *Determine whether the subcontractors have a monitoring system to address program integrity cases, along with methods and criteria for identifying, tracking, and resolving FWA cases.*
    - *Ensure subcontractors have adopted and implemented training programs, which include FWA components.*
    - *Review reports to confirm evidence of the subcontractors' oversight activities.*

- *Review the subcontractors' organizational structure, including local and corporate staff. Determine whether they have dedicated local health plan staff performing oversight and monitoring activities.*
- *Confirm that contracts between AGP and subcontractors outline program integrity responsibilities and include sanctions for non-performance.*
- *Review corrective action procedures administered, if any, by AGP as a result of subcontractor contractual non-compliance.*

- *We will request that AGP and its subcontractors identify and provide Georgia Families 360° program policies and procedures related to the following areas:*
  - *Care Coordination.*
  - *Georgia Families 360° Member Enrollment and Disenrollment.*
  - *Internal Grievance/Appeals System.*
  - *Member Call Center.*
  - *Provider Network.*
  - *Quality Improvement.*
  - *Required Assessments and Screenings.*
  - *Utilization Management.*
- *The following procedures will be performed:*
  - *We will:*
    - *Review, then determine if the policies are in accordance with the contract between DCH and AGP.*
    - *Review the information provided during the AGP staff interviews, then determine if responses are in accordance with the contract between DCH and AGP.*

Appendix C: Georgia Families Policy and Procedure Review

Behavioral Health Services

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.5.4.3 For Medicaid children under twenty-one (21) years of age, the Contractor is required to provide Medically Necessary Services to correct or ameliorate physical and Behavioral Health disorders, a defect, or a condition identified during an EPSDT screening or preventive visit regardless of whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.6.11.6 The Contractor shall permit all initial outpatient Behavioral Health (mental health and substance abuse) evaluation, diagnostic testing, and assessment services to be provided without Prior Authorization. The Contractor shall permit up to three (3) initial evaluations per year for Members younger than twenty-two (22) years of age without requiring additional Prior Authorization.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.6.11.7 Following an initial evaluation, the Contractor shall permit up to twelve (12) outpatient counseling/therapy visits to be provided without Prior Authorization.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.6.11.8 The Contractor shall promote the delivery of Behavioral Health services in the most integrated and person-centered setting including in the home, school or community, for example, when identified through care planning as the preferred setting by the Member. The delivery of home and community based Behavioral Health services may be incentivized by the Contractor for Providers who engage in this person-centered service delivery.	Yes
4.8.4.5 The Contractor will include Behavioral Health Homes in its Medical Home network. Behavioral Health Home providers do not need to provide all the services of a traditional Medical Home themselves, but must ensure that the full array of primary and Behavioral Health Care services is available, integrated and coordinated. The number of behavioral Health Homes proposed in the network should be responsive to the prevalence of members with severe and persistent mental illness or chronic behavioral health conditions. The proposed algorithm along with assignment of Behavioral Health Homes shall be included in a Medical Home implementation plan.	Yes
4.8.9.1 The Contractor shall include in its network the three tiers of community Behavioral Health Providers listed below that meet the requirements of the Department of Behavioral Health and Developmental Disabilities, provided they have been credentialed to participate in Medicaid for that provider type and agree to the Contractor's terms and conditions as well as rates.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.8.9.1.1 Tier 1: Comprehensive Community Providers (CCP) 4.8.9.1.1.1 CCPs function as the safety net for the target population, serve the most vulnerable and respond to critical access needs. The standards and requirements for CCPs are found in CCP Standards for Georgia's Tier 1 Behavioral Health Safety Net, 01-200.	Yes
4.8.9.1.2 Tier 2: Community Medicaid Providers (CMPs) 4.8.9.1.2.1 CMPs provide Behavioral Health services and supports identified in the Medicaid State Plan for Serious Emotional Disturbance (SED) youth, young adults, Serious and Persistent Mental Illness (SPMI) Adults, and individuals with Substance Use Disorders (SUDs).	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.8.9.1.3 Tier 3: Specialty Providers (SPs) 4.8.9.1.3.1 SPs offer an array of specialty services including but not limited to: 4.8.9.1.3.1.1 Intensive Family Intervention providers for children who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.8.9.1.3.1.2 Certified Peer Specialists (CPS) with lived experience for both young adults and adults to include CPS-Parents who are associated with a Family Support Organization (i.e. Federation of Families), CPS-Addiction and CPS Whole Health and Wellness.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.8.9.1.3.1.3 Care Management Entities to provide intensive, customized, complex Care Coordination for children, youth, and young adults who have mental illness/serious emotional disturbance (or similar diagnosis) and their families.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.8.9.1.3.1.4 Assertive Community Treatment for adults with SPMI.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.8.9.2 Additionally, the Contractor shall include in its Provider network Providers who are enrolled as psychologists under the State Plan.	Yes
4.8.9.3 The Contractor shall maintain copies of all letters and other correspondence related to the inclusion of Community Behavioral Health Providers in its network. This documentation shall be provided to DCH upon request.	Yes
4.9.2.1 The Contractor shall provide a Provider Handbook to all Providers. Upon request, the Contractor shall mail a hard copy to the Provider. The Provider Handbook shall serve as a source of information regarding GF Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the Provider Handbook shall include the following information: 4.9.2.1.10 Physical Health and Behavioral Health Coordination including the requirement for Behavioral Health Providers to send status reports to PCPs and PCPs to send status reports to Member's Behavioral Health Providers;	Yes
4.11.8.2 The Contractor must develop and implement Care Coordination and Continuity of Care. Policies and procedures are designed to accommodate the specific cultural and linguistic needs of the Contractor's Members.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.11.8.4 The Contractor is encouraged to use Community Health Workers in the engagement of Members in Care Coordination activities. This includes: Transition of Care, Discharge Planning; Care Coordination, Coordination with Other Entities, Physical Health and Behavioral Health Integration, Disease Management and Case Management.	Yes
4.11.8.9.1 The Contractor shall develop an innovative approach to encourage PCPs, Behavioral Health Providers, and dental Providers to effectively and efficiently share behavioral and physical health clinical Member information, including how the Contractor will notify Behavioral Health Providers and PCPs after an inpatient mental health stay.	Yes
4.11.8.9.2 The Contractor must require Behavioral Health Providers to send initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement shall be specified in all Provider Handbooks.	Yes
4.11.8.9.3 The Contractor shall submit an annual Health Coordination and Integration Report to the Department due June 30th of each calendar year for the prior calendar year beginning 2017. This report is subject to approval by the Department. At a minimum, this report shall include: 4.11.8.9.3.1 Program Goals and Objectives 4.11.8.9.3.2 Summary of activities and efforts to integrate and coordinate behavioral and physical health; 4.11.8.9.3.3 Successes (e.g., exceeding performance targets) and opportunities for improvement; 4.11.8.9.3.4 Plans to implement initiatives to address identified opportunities for these improvements and to achieve expected outcomes; and 4.11.8.9.3.5 Roadmap of activities planned for the next reporting.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.11.10.8 The Contractor must notify DCH of the specific Case Management programs it initiates (i.e. OB Case Management, Behavioral Health case management, etc.) and terminates and provide evidence, on an annual basis, of the effectiveness of such programs for its enrolled Members.	Yes

Call Center Operations

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Member Call Center Operations	
4.3.7.1 Amerigroup shall operate a toll-free telephone line to respond to Member questions and comments.	Yes
4.3.7.2 Amerigroup shall develop call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.3.7.3 Amerigroup shall submit these call center policies and procedures, including performance standards, to DCH for initial review and approval within sixty (60) Calendar Days of the Contract Effective Date, and as updated thereafter.	Yes
4.3.7.4 The call center must comply with Title IV of the Civil Rights Act. The call center shall be equipped to handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.	Yes
4.3.7.5 Amerigroup shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The call center staff shall be trained to accurately respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, Amerigroup shall have an automated system available between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday and at all hours on weekends and State holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. A Contractor's Representative shall return messages on the next Business Day.	Yes
4.3.7.6 Amerigroup shall achieve performance standards and monitor call center performance by recording calls and employing other Monitoring activities Amerigroup shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. Amerigroup shall submit the Call Center Quality Criteria and Protocols to DCH Provider Services for review and approval annually. At a minimum, the standards shall require that, on a Calendar month basis:	Yes
4.3.7.6.1 Average Speed of Answer: Ninety percent (90%) of calls shall be answered by a person within thirty (30) seconds with the remaining ten percent (10%) answered within an additional thirty (30) seconds by a live operate measured weekly. "Answer" shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative.	Yes
4.3.7.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.3.7.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).	Yes
4.3.7.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a Call Center Representative.	Yes
4.3.7.6.5 Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.	Yes
4.3.7.6.6 Accurate Response to Call Center Phone Inquiries: Call center representatives accuracy rate must be ninety percent (90%) or higher.	Yes
4.3.7.7 Amerigroup shall establish remote phone monitoring capabilities for at least five (5) DCH staff. DCH or its Agent shall be able, using a personal computer and/or phone, to monitor call center and field office calls in progress and to identify the number of call center staff answering calls and the identity of the individual call center staff answering the calls.	Yes
4.3.10.1 Amerigroup shall provide oral interpretation services of information to any Member who speaks any non-English language regardless of whether a Member speaks a language that meets the threshold of a Prevalent Non-English Language. Amerigroup shall notify its Members of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the Member for interpretation services.	Yes
Provider Call Center Operations	
4.9.5.1 The Contractor shall operate a toll-free call center to respond to Provider questions, comments, and concerns.	Yes
4.9.5.2 The Contractor shall develop call center Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.9.5.3 The Contractor shall submit these call center Policies and Procedures, including performance standards, to DCH for initial review and approval as updated thereafter.	Yes
4.9.5.4 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment K.	Yes
4.9.5.5 Pursuant to O.C.G.A. 33-20A-7.1(c), the call center shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-Certification requests. This call center shall have staff to respond to Provider questions in all other areas, including the Provider complaint system, Provider responsibilities, etc. between the hours of 7:00am and 7:00pm EST Monday through Friday, excluding State holidays. The Contractor shall ensure that after regular business hours the non-Prior Authorization/ Pre-certification line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Member with an Emergency or	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Urgent Medical Condition. The call center shall have the capability for callers to leave a message, which shall be returned within twenty-four (24) clock hours. The requirement that the Contractor shall provide information to Providers on how to verify enrollment for a Member with an Emergency or Urgent Medical Condition shall not be construed to mean that the Provider must obtain verification before providing Emergency Services.	
4.9.5.6 The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Contractor shall submit the call center Quality Criteria and Protocols to DCH Provider Services for initial review and approval and as updated thereafter. At a minimum, the standards shall require that, on a Calendar month basis:	Yes
4.9.5.6.1 Average Speed of Answer: Eighty percent (80%) of calls shall be answered by a person within thirty (30) seconds. “Answer” shall mean for each caller who elects to speak, is connected to a live representative. The caller shall not be placed on hold immediately by the live representative. The remaining twenty percent (20%) of calls shall be answered within one (1) minute of the call.	Yes
4.9.5.6.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.	Yes
4.9.5.6.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).	Yes
4.9.5.6.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a live Call Center Representative.	Yes
4.9.5.6.5 Timely Response to call center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of “closed” for this performance measure.	Yes
4.9.5.6.6 Accurate Response to Call Center Phone Inquiries: Call Center representatives accuracy rate must be ninety percent (90%) or higher.	Yes
4.9.5.7 The Contractor shall set up remote phone monitoring capabilities for at least ten (10) DCH staff. DCH shall be able, using a personal computer or phone, to monitor call Center and field office calls in progress and to identify the number of call center staff answering calls and the call center staff identifying information. The Contractor will facilitate bi-annual calibration sessions with DCH. The purpose of the calibration sessions is to ensure call center monitoring findings conducted by DCH and the Contractor are consistent.	Yes

Internal Grievance/Appeal System

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.14.1 Appeals Process	
4.14.1.1 The Contractor's Grievance System shall include a process to receive, track, resolve and report on Grievances from its Members. The Contractor's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Contractor's Appeals Process shall include an internal process that must be exhausted by the Member prior to accessing an Administrative Law Hearing. See O.C.G.A. §49-4-153.	Yes
4.14.1.2 The Contractor shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Contractor's policies and procedures shall be available in the Member's primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for initial review and approval, and as updated thereafter.	Yes
4.14.1.3 The Contractor shall process each Grievance and Administrative Review using applicable State and federal laws and regulations, the provisions of this Contract, and the Contractor's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.	Yes
4.14.1.4 The Contractor shall give Members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.	Yes
4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.	Yes
4.14.1.6 The Contractor shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision making; and are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease if deciding any of the following:	Yes
4.14.1.6.1 An Appeal of a denial that is based on lack of Medical Necessity;	Yes
4.14.1.6.2 A Grievance regarding denial of expedited resolutions of an Administrative Review; and	Yes
4.14.1.6.3 Any Grievance or Administrative Review that involves clinical issues.	Yes
4.14.3.3 The Contractor shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance resolutions.	Yes
4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.14.3 Grievance Process	
4.14.3.1 A Member or Member's Authorized Representative may file a Grievance to the Contractor either orally or in writing. A Grievance may be filed about any matter other than a Proposed Action. A Provider cannot file a Grievance on behalf of a Member.	Yes
4.14.3.2 The Contractor shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals, under the supervision of the Contractor's Medical Director, who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease and who were not involved in any previous level of review or decision-making.	Yes
4.14.3.3 The Contractor shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance resolutions.	Yes
4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.	Yes

Member Services

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.3.1.1 The Contractor shall ensure that Members are aware of the following:	
4.3.1.1.1 Member rights and responsibilities	Yes
4.3.1.1.2 The role of PCPs and Dental Home	Yes
4.3.1.1.3 The role of the Family Planning Provider and PCP (for IPC P4HB Participants only)	Yes
4.3.1.1.4 How to obtain care	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.3.1.1.5 What to do in an emergency or urgent medical situation (for P4HB participants information must address what to do in an emergency or urgent medical situation arising from the receipt of Demonstration related Services)	Yes
4.3.1.1.6 How to request a Grievance, Appeal, or Administrative Law Hearings	Yes
4.3.1.1.7 How to report suspected Fraud and Abuse	Yes
4.3.1.1.8 Providers who have been terminated from the Contractor's network	No. There was no specific reference to this section of the contract in the submitted

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.3.1.2 The Contractor must be prepared to utilize all forms of population-appropriate communication to reach the most Members and engender the most responses. Examples of communications include but are not limited to telephonic; hard copy via mail; social media; texting; and email that allow Members to submit questions and receive responses from the Contractor while protecting the confidentiality and PHI of the Members in all instances. The Contractor shall attempt to collect/obtain Member email addresses from Members. Upon request, the Contractor must provide materials in the format preferred by the Member.	Yes
4.3.2.1 The Contractor shall make all written materials available in a manner that takes into consideration the Member's needs, including those who are visually impaired or have limited reading proficiency. The Contractor shall notify all Members that information is available in alternative formats and how to access those formats.	Yes
4.3.2.2 The Contractor shall make all written information available in English, Spanish and all other prevalent non-English languages, as defined by DCH. For the purposes of this Contract, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State, as defined by DCH.	Yes
4.3.2.3 All written materials distributed to Members shall include a language block, printed in Spanish and all other prevalent non-English languages, that informs the Member that the document contains important information and directs the Member to call the Contractor to request the document in an alternative language or to have it orally translated.	Yes
4.3.2.4 All written materials shall be worded such that they are understandable to a person who reads at the fifth (5th) grade level.	Yes
4.3.2.5 The Contractor shall provide written notice to DCH of any changes to any written materials provided to the Members. Written notice shall be provided at least thirty (30) Calendar Days before the effective date of the change.	Yes
4.3.2.6 The Contractor must submit all written materials, including information for the Contractor's Web site, to DCH for approval prior to use or mailing. DCH will approve or identify any required changes to the Member materials within thirty (30) Calendar Days of submission. DCH reserves the right to require the discontinuation of any Member materials that violate the terms of this Contract.	Yes
4.3.3.1 The Contractor shall provide a Member Handbook, a P4HB participant Handbook, and other programmatic information to Members. The Contractor shall make the Member and P4HB participant Handbook available to Members through the Contractor's web site. Upon request, the Contractor shall mail a hard copy of the Member Handbook to enrolled Member households and a P4HB participant information packet to P4HB participant households.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.3.3.2 The Member Handbook shall include all requirements set forth in 42 CFR 438.10.	Yes
4.3.6.1 The Contractor shall mail via surface mail a Member ID Card to all new Members according to the following timeframes: 4.3.6.1.1 Within seven (7) Calendar Days of receiving the notice of Enrollment from DCH or the Agent for Members who have selected a CMO and a PCP.	Yes
4.3.6.3 The Contractor shall reissue the Member ID Card within seven (7) Calendar Days of notice if a Member reports a lost card, there is a Member name change, the PCP changes, or for any other reason that results in a change to the information disclosed on the Member ID Card.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.3.6.4 The Contractor shall submit a front and back sample Member ID Card to DCH for initial review and approval, within sixty (60) Calendar Days of the Contract Effective Date and approval and as updated thereafter.	Yes
4.3.6.5 The Contractor shall mail via surface mail a P4HB participant ID Card to all new P4HB participants in the Demonstration within Seven (7) Calendar Days of receiving the notice of Enrollment from DCH or its Agent. The P4HB participant's ID Card will meet the requirements set forth for Member ID Cards in Sections 4.3.6.2 (excluding Section 4.3.6.2.4), 4.3.6.3 and 4.3.6.4, and will identify the Demonstration component in which the P4HB participant is enrolled:	Yes
4.3.6.5.1 A Pink color will signify the P4HB participants as eligible for Family Planning Services Only.	Yes
4.3.6.5.2 A Purple color will signify the P4HB participants as eligible for Interpregnancy Care Services and Family Planning Services.	Yes
4.3.6.5.3 A Yellow color will signify the P4HB participant as eligible for Case Management – Resource Mothers Outreach Only.	Yes
4.3.6.6 Each time the P4HB participant's ID card is issued or re-issued to a P4HB participant, the Contractor shall provide written materials that explain the meaning of the color coding of the ID card and its relevance to Demonstration benefits.	Yes
4.3.3.1 The Contractor shall provide a Member Handbook, a P4HB participant Handbook, and other programmatic information to Members. The Contractor shall make the Member and P4HB participant Handbook available to Members through the Contractor's website. Upon request, the Contractor shall mail a hard copy of the Member Handbook to enrolled Member households and a P4HB participant information packet to P4HB participant households.	Yes

Member Data Maintenance

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) Yes or No
4.17.1.1 The Contractor shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet GF requirements, State and federal reporting requirements, all other Contract requirements and any other applicable State and federal laws, rules and regulations, as amended, including HIPAA.	Yes
4.17.1.1.1 Contractor shall have information management processes and information Systems that enable it to retain and maintain access to Provider's historical information for the purpose of claims processing and Provider inquiries for a period of up to five (5) years.	Yes
4.17.1.2 The Contractor is responsible for maintaining Systems that shall possess capacity sufficient to handle the workload projected for the start of the program and will be scalable and flexible enough to adapt as needed, within negotiated timeframes, in response to program or Enrollment changes.	Yes
4.17.1.3 The Contractor shall provide a Web-accessible system hereafter referred to as the DCH Portal that designated DCH and other state agency resources can use to access Quality and performance management information as well as other system functions and information as described throughout this Contract. Access to the DCH Portal shall be managed as described in the System and Data Integration Requirements below.	Yes
4.17.1.4 The Contractor shall attend DCH's Systems Work Group meetings as scheduled by DCH. The Systems Work Group will meet on a designated schedule as agreed to by DCH, its Agents and every Contractor.	Yes
4.17.1.5 The Contractor shall provide a continuously available electronic mail communication link (E-mail system) with the State. This system shall be:	Yes
4.17.1.5.1 Available from the workstations of the designated Contractor contacts; and	Yes
4.17.1.5.2 Capable of attaching and sending documents created using software products other than Contractor systems, including the State's currently installed version of Microsoft Office and any subsequent upgrades as adopted.	Yes
4.17.1.6 By no later than the 30th of April of each year, the Contractor will provide DCH with an annual progress/status report of the Contractor's Systems refresh plan for the upcoming State fiscal year. The plan will outline how Systems within the Contractor's Span of Control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or Systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The Systems refresh plan will also indicate how the Contractor will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) Yes or No
development firm (SDF) or a third party authorized by the OEM and/or SDF to support the Systems' components.	
4.17.1.7 The Contractor is responsible for all costs associated with the Contractor's Systems refresh plan.	Yes
4.17.2.1 The Contractor shall have in place or develop initiatives towards implementing electronic health information exchange and health care transparency to encourage the use of Qualified Electronic Health Records and make available to Providers and Members increased information on cost and Quality of care through health information technology.	Yes
4.17.2.2 The Contractor shall develop an incentive program for the adoption and utilization of electronic health records that result in improvements in the Quality and cost of health care services. This incentive program shall be submitted to DCH initially and as revised thereafter. The Contractor shall provide to DCH quarterly reports illustrating adoption of electronic health records by Providers.	Yes
4.17.2.3 The Contractor shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).	Yes
4.17.2.3.1 If not already participating in the GaHIN, the Contractor shall sign and execute all required GaHIN participation documentation within ten (10) Calendar Days of the Contract Effective Date (or an alternative date approved in writing by DCH) and shall adhere to all related policy and process requirements as a QE in the GaHIN. Such application process shall include successful completion of the GaHIN accreditation process;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.3.2 The Contractor shall make business and technology resources available to work with the GaHIN technology vendor to develop, implement and test technical interfaces and other interoperability services as deemed necessary by DCH;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.3.3 DCH and/or its designee shall provide detailed on-boarding information for use by the Contractor to establish interoperability with the GaHIN; and	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) Yes or No
	Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.3.4 Costs incurred by the Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4 The Contractor shall make Member health information accessible to the GaHIN.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1 Through their system and interoperability with the GaHIN, the Contractor shall provide the following types of patient health information on Members including, but not limited to:	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) Yes or No
	provided and established internally after the transition to Velatura."
4.17.2.4.1.1 Member-specific information including, but not limited to name, address of record, date of birth, race/ethnicity, gender and other demographic information, as appropriate;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.2 Name and address of each Member's PCP;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.3 Acquisition and retention of the Member's Medicaid ID;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.4 Provider-specific information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) Yes or No
	transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.5 Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Health Check program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnoses, and treatment given, including drugs prescribed;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.6 Record of future scheduled service appointments, if available, and referrals;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.7 Complete record of all immunizations;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) Yes or No
	internally after the transition to Velatura."
4.17.2.4.1.8 Listing of the Member's Durable Medical Equipment (DME), which shall be reflected in the claims or "visits" module of the VHR; and	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.9 Any utilization of an informational code set, such as ICD-9 or ICD-10, which should provide the used code value as well as an appropriate and understandable code description.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.5 The Contractor shall access the GaHIN to display Member health information within their system for the purpose of Care Coordination and management of the Members.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.6 The Contractor shall provide DCH with a list of Authorized Users who may access patient health data from the Contractor's Systems. DCH shall review and approve the list, including revisions thereto, of the Contractor's Authorized Users who may access	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) Yes or No
patient health data from the Contractor's systems. The Contractor shall be permitted to access the GaHIN for purposes associated with this Contract only.	information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.8 The Contractor shall encourage contracted Providers' participation in the GAHIN as well.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."

Monitoring and Reporting

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.18.1.1 The Contractor shall support DCH in its program monitoring and reporting efforts for program performance and trending analyses through submission of ongoing, dashboard and ad hoc reports to DCH for all activities described in the Contract. The Contractor shall provide ad hoc reports to DCH upon request and within timeframes agreed to by DCH and the Contractor.	Yes
4.18.1.2 The Contractor shall meet with DCH Business Owners during implementation to discuss all data requirements and the Contractor's recommended reports. The Contractor shall accommodate DCH's requests for data and reporting based on implementation decisions as well as for ongoing requests during operations.	Yes
4.18.2.1 The Contractor shall collect, validate and report required program data to DCH in an accurate and timely manner. The Contractor's Chief Executive or Financial Officer, or a designee vested with their authority, shall attest to the accuracy and completeness of all submitted reports, in accordance with 42 CFR §438.604. In addition, the Contractor shall comply with all state and federal requirements set forth in this Section and throughout this Contract.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.18.2.2 The Contractor shall comply with all the reporting requirements established by this Contract and shall submit all Reports included in this Contract. The Contractor shall create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH, at no cost to DCH. DCH may modify reports, specifications, templates, or timetables as necessary during the Contract year. Contractor changes to the format must be approved by DCH prior to implementation. The Contractor shall transmit and receive all transactions and code sets required by the HIPAA regulations in accordance with Section 23.2. The Contractor's failure to submit the Reports as specified may result in the assessment of liquidated damages as described in Section 25.0.	No. Per AGP, "Although there is no policy document specific to this requirement, the standard operating procedure in place is Compliance and the Regulatory Reporting Center of Expertise (COE) monitors DCH reporting requirements via the Medicaid Contract and the DCH SharePoint site which houses the DCH Schedule of Reports and DCH approved report Specifications and Templates."
4.18.2.2.1 The Contractor shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, unless otherwise indicated.	Yes
4.18.2.2.1.1 Weekly Reports shall be submitted on the same day of each week as determined by DCH;	Yes
4.18.2.2.1.2 Monthly Reports shall be submitted within fifteen (15) Calendar Days of the end of each month;	Yes
4.18.2.2.1.3 Quarterly Reports shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;	Yes
4.18.2.2.1.4 Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12th) month of the contract year ending June 30th;	Yes
4.18.2.2.1.5 Ad-Hoc, as determined by DCH; and	Yes
4.18.2.2.1.6 Other Reports (bi-annual, according to the due date of the respective report).	Yes
4.18.2.2.2 For reports required by DOI and DCH, the Contractor shall submit such reports according to the DOI schedule of due dates, unless otherwise indicated. While such schedule may be duplicated in this Contract, should the DOI schedule of due dates be amended at a future date, the due dates in this Contract shall automatically change to the new DOI due dates.	Yes
4.18.2.2.3 The Contractor shall, upon request of DCH, generate any additional data or reports at no additional cost to DCH within a time period prescribed by DCH. The Contractor's responsibility shall be limited to data in its possession.	Yes
4.18.3.1 DCH will periodically publish information or receive requests from audiences such as legislators that may require data from the Contractor. DCH will provide the Contractor with information about the data DCH would like to publish or must produce, and the Contractor shall produce all reports or summary data for DCH to incorporate into a larger report. The Contractor shall develop these reports considering the audience to be targeted.	Yes
4.18.3.2 The Contractor shall not publish reports on its website or any other forum without prior consent from DCH.	No. Per AGP, "Although there is no policy document specific to this requirement, the

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	standard operating procedure is to always obtain DCH approval before placing any report or any other information on the AMGP GA Website."
4.18.4.1 The Contractor must be prepared to participate in regularly scheduled meetings with DCH staff to review decisions, resolve issues and define operational enhancements. These meeting schedules will be determined by DCH.	No. Per AGP, AMGP GA leadership is notified by DCH of meetings via email to Compliance or the Plan President. Currently, there is a monthly DCH/CEO meeting attended by AMGP GA leadership. There is a monthly DCH/CMO Operations meeting attended by designated AMGP staff. Upon request/notice from DCH of any other DCH meeting, the Plan President or Compliance ensures appropriate staff are identified to attend.
4.18.4.2 The Contractor and its various levels of staff as determined by DCH must also attend an onsite meeting at DCH to report on all activities, trends, opportunities for improvement and recommendations for programmatic and policy changes at the frequency determined by DCH. Contractors must provide best practices and lessons learned to reach GF program goals.	No. Per AGP, "Prior to the COVID Pandemic, both the DCH/CEO meeting and the DCH/CMO Ops meeting were attended on site at the DCH Peachtree office. Due to the Pandemic these meetings were switch to virtual and will continue to be virtual until DCH communicates a change."

Pharmacy Services

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.6.6.1 The Contractor is permitted to establish a Maximum Allowable Cost (MAC) schedule. However, the Contractor must ensure the MAC pricing schedule is evaluated for pricing appropriateness and updated as appropriate no less frequently than every two (2) weeks.	Yes
4.6.6.1.1 The MAC must be reviewed no less frequently than every two (2) weeks to ensure:	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.6.6.1.1.1 Appropriateness of pricing;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.6.6.1.1.2 MAC pricing schedule does not create a barrier to access to the medication;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.6.6.1.1.3 Each medication represented on the MAC schedule has at least two (2) A-rated generic equivalents available in the Georgia marketplace;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.6.6.1.2 The MAC pricing schedule must be posted on the Contractor's website; and	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.6.6.1.3 The Contractor must make available an inquiry and appeal process for Provider disputes over the MAC schedule or individual drugs subject to the MAC pricing with all inquiries and appeals being addressed within five (5) calendar days of the receipt of the Provider inquiry or appeal.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.6.6.2 The Contractor shall provide pharmacy services either directly or through a Pharmacy Benefits Manager (PBM). The Contractor or its PBM may establish a preferred drug list if the following minimum requirements are met:	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.6.6.2.1 Appropriate selection of drugs from therapeutic drug classes are accessible and are sufficient in amount, duration, and scope to meet Members' medical needs;	No. There was no specific reference to this section of the contract in the submitted policy documents; however,

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	interviews with AGP staff supported that these functions are occurring.
4.6.6.2.2 The only excluded drug categories are those permitted under Section 1927(d) of the Social Security Act;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.6.6.2.3 A Pharmacy & Therapeutics Committee that advises and/or recommends preferred drug list decisions is established and maintained; and	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.6.6.2.4 Over the counter medications specified in the Georgia State Medicaid Plan are included in the formulary.	Yes
4.6.6.3 The Contractor shall make available to P4HB participants folic acid and/or a multivitamin with folic acid.	Yes
4.6.6.4 The Contractor shall make the preferred drug list, utilization limits and conditions for coverage for prior authorized drugs available through its website and provide such documentation to DCH upon request.	Yes
4.6.6.5 The Contractor shall have an automated electronic Prior Authorization portal for the submission of Prior Authorization requests and encourage adoption by Providers. Regardless of whether Providers submit prior authorization requests manually or through the portal, the Contractor shall:	Yes
4.6.6.5.1 Provide a response by telephone or other telecommunication device within twenty-four (24) hours of a request for Prior Authorization.	Yes
4.6.6.5.2 Provide for the dispensing of at least a seventy-two (72)-hour supply of a covered outpatient prescription drug in an emergency situation.	Yes
4.6.6.5.3 Resolve all pharmacy prior authorization requests within twenty-four (24) hours unless additional information is required from the prescriber. If additional information is needed from the prescriber, documented telephonic or other telecommunication contact with the prescriber must be made every twenty-four (24) hours up to a final disposition within seventy-two (72) hours of receipt of the request.	Yes
4.6.6.6 If the Contractor chooses to implement a mail-order pharmacy program, any such program must be established and maintained in accordance with State and federal law. The Contractor shall not require Members to use a mail-order pharmacy to receive covered pharmacy Benefits, but may allow Members to use a mail-order pharmacy if:	Yes
4.6.6.6.1 Mail-order delivery is clinically appropriate;	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.6.6.6.2 The pharmacy is willing to accept payments and terms as described in this Contract;	Yes
4.6.6.6.3 Cost sharing is no more than it is for Members utilizing services by retail pharmacy;	Yes
4.6.6.6.4 The Member expressed desire to receive pharmacy services by mail-order; and	Yes
4.6.6.6.5 The Member is allowed to cease mail-order pharmacy services and utilize retail pharmacies at any time.	Yes
4.6.6.7 Contractor must ensure that entities which are a part of the 340B Drug Pricing Program are identified for the purposes required under federal statute regarding drug rebates. Any arrangements that are made (e.g. 340B provider agrees to use or not use 340B drugs when providing services for the GF/GF 360 program, Contractor pays a reduced rate for 340B products, etc.) are at the discretion of Contractor and the providers. However, any time 340B product is used under the GF/GF 360 program, it will have to be identified within the encounter data on the claim pursuant to Section 4.16.3.6.18 to ensure that DCH does not include those claims in any drug rebate invoices, as required by federal statute.	Yes

Provider Data Maintenance

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.17.1.1 The Contractor shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet GF requirements, State and federal reporting requirements, all other Contract requirements and any other applicable State and federal laws, rules and regulations, as amended, including HIPAA.	Yes
4.17.1.1.1 Contractor shall have information management processes and information Systems that enable it to retain and maintain access to Provider's historical information for the purpose of claims processing and Provider inquiries for a period of up to five (5) years.	Yes
4.17.1.2 The Contractor is responsible for maintaining Systems that shall possess capacity sufficient to handle the workload projected for the start of the program and will be scalable and flexible enough to adapt as needed, within negotiated timeframes, in response to program or Enrollment changes.	Yes
4.17.1.3 The Contractor shall provide a Web-accessible system hereafter referred to as the DCH Portal that designated DCH and other state agency resources can use to access Quality and performance management information as well as other system functions and information as described throughout this Contract. Access to the DCH Portal shall be managed as described in the System and Data Integration Requirements below.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.17.1.4 The Contractor shall attend DCH's Systems Work Group meetings as scheduled by DCH. The Systems Work Group will meet on a designated schedule as agreed to by DCH, its Agents and every Contractor.	Yes
4.17.1.5 The Contractor shall provide a continuously available electronic mail communication link (E-mail system) with the State. This system shall be: 4.17.1.5.1 Available from the workstations of the designated Contractor contacts; and 4.17.1.5.2 Capable of attaching and sending documents created using software products other than Contractor systems, including the State's currently installed version of Microsoft Office and any subsequent upgrades as adopted.	Yes
4.17.1.6 By no later than the 30th of April of each year, the Contractor will provide DCH with an annual progress/status report of the Contractor's Systems refresh plan for the upcoming State fiscal year. The plan will outline how Systems within the Contractor's Span of Control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or Systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The Systems refresh plan will also indicate how the Contractor will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF) or a third party authorized by the OEM and/or SDF to support the Systems' components.	Yes
4.17.1.7 The Contractor is responsible for all costs associated with the Contractor's Systems refresh plan.	Yes
4.17.2.1 The Contractor shall have in place or develop initiatives towards implementing electronic health information exchange and health care transparency to encourage the use of Qualified Electronic Health Records and make available to Providers and Members increased information on cost and Quality of care through health information technology.	Yes
4.17.2.2 The Contractor shall develop an incentive program for the adoption and utilization of electronic health records that result in improvements in the Quality and cost of health care services. This incentive program shall be submitted to DCH initially and as revised thereafter. The Contractor shall provide to DCH quarterly reports illustrating adoption of electronic health records by Providers.	Yes
4.17.2.3 The Contractor shall participate in the Georgia Health Information Network (GaHIN) as a Qualified Entity (QE).	Yes
4.17.2.3.1 If not already participating in the GaHIN, the Contractor shall sign and execute all required GaHIN participation documentation within ten (10) Calendar Days of the Contract Effective Date (or an alternative date approved in writing by DCH) and shall adhere to all related policy and process requirements as a QE in the GaHIN. Such application process shall include successful completion of the GaHIN accreditation process;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange,

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.3.2 The Contractor shall make business and technology resources available to work with the GaHIN technology vendor to develop, implement and test technical interfaces and other interoperability services as deemed necessary by DCH;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.3.3 DCH and/or its designee shall provide detailed on-boarding information for use by the Contractor to establish interoperability with the GaHIN; and	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.3.4 Costs incurred by the Contractor to establish interoperability with the GaHIN shall be the sole responsibility of the Contractor.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.17.2.4 The Contractor shall make Member health information accessible to the GaHIN.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1 Through their system and interoperability with the GaHIN, the Contractor shall provide the following types of patient health information on Members including, but not limited to:	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.1 Member-specific information including, but not limited to name, address of record, date of birth, race/ethnicity, gender and other demographic information, as appropriate;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.2 Name and address of each Member's PCP;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.3 Acquisition and retention of the Member's Medicaid ID;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.4 Provider-specific information including, but not limited to, name of Provider, professional group, or facility, Provider's address and phone number, and Provider type including any specialist designations and/or credentials;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.5 Record of each service event with a physician or other Provider, including routine checkups conducted in accordance with the Health Check program. Record should include the date of the service event, location, Provider name, the associated problem(s) or diagnoses, and treatment given, including drugs prescribed;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.17.2.4.1.6 Record of future scheduled service appointments, if available, and referrals;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.7 Complete record of all immunizations;	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.8 Listing of the Member's Durable Medical Equipment (DME), which shall be reflected in the claims or "visits" module of the VHR; and	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.4.1.9 Any utilization of an informational code set, such as ICD-9 or ICD-10, which should provide the used code value as well as an appropriate and understandable code description.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.5 The Contractor shall access the GaHIN to display Member health information within their system for the purpose of Care Coordination and management of the Members.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.6 The Contractor shall provide DCH with a list of Authorized Users who may access patient health data from the Contractor's Systems. DCH shall review and approve the list, including revisions thereto, of the Contractor's Authorized Users who may access patient health data from the Contractor's systems. The Contractor shall be permitted to access the GaHIN for purposes associated with this Contract only.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."
4.17.2.8 The Contractor shall encourage contracted Providers' participation in the GAHIN as well.	No. Per AGP, "Amerigroup IT Account Manager is the Amerigroup-specific GAHIN Administrator. Per the current transition to Velatura's health information exchange, Amerigroup's onboarding is rolling out from October – November 2021. Documentation will be provided and established internally after the transition to Velatura."

Provider Complaints

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.9.7.1 The Contractor shall establish a Provider Complaint system that permits a Provider to dispute the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.	Yes
4.9.7.2 The Contractor shall submit its Provider Complaint System Policies and Procedures to DCH for review and approval quarterly and annually and as updated thereafter. The Contractor shall include its Provider Complaint System Policies and Procedures in its Provider Handbook that is distributed to all network Providers. This information shall include, but not be limited to, specific instructions regarding how to contact the Contractor's Provider services to file a Provider complaint and which individual(s) have the authority to review a Provider complaint.	Yes
4.9.7.3 The Contractor shall distribute the Provider Complaint System Policies and Procedures to Out-of-Network Providers with the remittance advice of the processed Claim. The Contractor may distribute a summary of these Policies and Procedures if the summary includes information on how the Provider may access the full Policies and Procedures on the Web site. This summary shall also detail how the Provider can request a hard copy from the Contractor at no charge to the Provider.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.9.7.4 As a part of the Provider Complaint System, the Contractor shall:	Intentionally left blank.
4.9.7.4.1 Allow Providers thirty (30) Calendar Days from the date of issue or incident to file a written complaint;	Yes
4.9.7.4.2 Allow Providers to consolidate complaints or appeals of multiple Claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment Claims included in the bundled complaint or appeal;	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.9.7.4.3 Require that Providers' complaints are clearly documented;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.4.4 Allow a Provider that has exhausted the Contractor's internal appeals process related to a denied or underpaid Claim or group of Claims bundled for appeal the option either to pursue the administrative appeals process described in O.C.G.A. § 49-4-153(e) or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution as described in O.C.G.A. § 33-21A-7. If the Contractor and the Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association.	No. There was no specific reference to this section of the contract in the submitted policy documents.

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) Calendar Days of being selected, unless the Contractor and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties;	
4.9.7.4.5 For all Claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from fifteen (15) Calendar Days after the date the Claim was submitted. The Contractor shall pay all interest required to be paid under this provision or Code Section O.C.G.A. 33-21A-7 automatically and simultaneously whenever payment is made for the Claim giving rise to the interest payment;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.4.6 Accurately identify all interest payments on the associated remittance advice submitted by the Contractor to the Provider;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.4.7 Require that Providers exhaust the Contractor's internal Provider Complaint process prior to requesting an Administrative Law Hearing (State Fair Hearing);	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.4.8 Have dedicated staff for Providers to contact via telephone, electronic mail, or in person, to ask questions, file a Provider Complaint and resolve problems;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.4.9 Identify a staff person specifically designated to receive and process Provider Complaints;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.4.10 Thoroughly investigate each GF Provider Complaint using applicable statutory, regulatory, and Contractual provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and	No. There was no specific reference to this section of the contract in the submitted policy documents; however,

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	interviews with AGP staff supported that these functions are occurring.
4.9.7.4.11 Ensure that Contractor executives with the authority to require corrective action are involved in the Provider Complaint process.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.5 In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Contractor shall provide a written Notice of Adverse Action to the Provider. The Notice of Adverse Action shall state that Providers may request an Administrative Law Hearing in accordance with O.C.G.A. § 49-4-153, O.C.G.A. § 50-13-13 and O.C.G.A. § 50-13-15.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.6 The Contractor shall notify the Providers that a request for an Administrative Law Hearing must include the following information:	Intentionally left blank.
4.9.7.6.1 A clear expression by the Provider that he/she wishes to present his/her case to an Administrative Law Judge;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.6.2 Identification of the Action being appealed and the issues that will be addressed at the hearing;	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.6.3 A specific statement of why the Provider believes the Contractor's Action is wrong; and	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.7.6.4 A statement of the relief sought.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	supported that these functions are occurring.
4.9.7.7 DCH has delegated its statutory authority to receive hearing requests to the Contractor. The Contractor shall include with the Notice of Adverse Action the Contractor's address where a Provider's request for an Administrative Law Hearing should be sent in accordance with O.C.G.A. § 49-4-153(e).	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.

Provider Network

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.8.1.1 The Contractor shall develop and maintain a network of Providers and facilities adequate to deliver Covered Services as described in the RFP and this Contract while ensuring adequate and appropriate provision of services to Members in rural areas, and which may include the use of telemedicine when appropriate to the condition and needs of the Member. The Contractor is solely responsible for providing a network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, Border Providers and other health care Providers through whom it provides the items and services included in Covered Services.	Yes
4.8.1.2 The Contractor shall include in its network only those Providers that have been appropriately credentialed by DCH or its Agent, that maintain current license(s), and that have appropriate locations to provide the Covered Services.	Yes
4.8.1.3 The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency.	Yes
4.8.1.4 The Contractor shall notify DCH sixty (60) Calendar Days in advance when a decision is made to close network enrollment for new Provider contracts and also notify DCH when network enrollment is reopened. The Contractor must notify DCH sixty (60) Calendar Days prior to closing a Provider panel.	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.8.1.5 The Contractor shall not include any Providers who have been excluded from participation by the United States Department of Health and Human Services, Office of Inspector General, or who are on the State's list of excluded Providers. The Contractor shall check the exclusions list on a monthly basis and shall immediately terminate any Provider found to be excluded and notify the Member per the requirements outlined in this Contract.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.

Provider Services

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.9.1.1 The Contractor shall provide information to all Providers about Georgia Families in order to operate in full compliance with the GF Contract and all applicable federal and State regulations.	Yes
4.9.1.2 The Contractor shall monitor Provider knowledge and understanding of Provider requirements, and take corrective actions to ensure compliance with such requirements.	Yes
4.9.1.3 Within sixty (60) Calendar Days of the Contract Effective Date, the Contractor shall submit to DCH for initial review and approval all materials and information to be distributed and/or made available to Providers about Georgia Families. Any proposed revisions to such materials and information thereafter shall also be submitted to DCH for prior review and approval. DCH will attempt to complete its review of such materials within thirty (30) Calendar Days of its receipt of such materials.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.1.4 All Provider Handbooks and bulletins must be in compliance with State and federal laws.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.9.1.5 Contractor must seek DCH's written approval of the Contractor's interpretation of policies in the Georgia Medicaid Policy Manual when such policies are referenced in Provider contracts or communications. DCH's review and response will be completed within sixty (60) Calendar Days of the Contractor's written request for approval of its policy interpretation. DCH's written response shall be final regarding any dispute of the meaning of that policy language. In the event the Contractor misinterprets a Medicaid policy which is communicated to Providers, the Contractor must submit a written corrective action plan to DCH within three (3) Business Days of notice from DCH. Contractor will be required to retroactively correct and adjust any previously adjudicated Claims or correct any other actions resulting from the misinterpreted policy language within thirty (30) Calendar Days of approval of the corrective action plan.	Yes
4.9.2.1 The Contractor shall provide a Provider Handbook to all Providers. Upon request, the Contractor shall mail a hard copy to the Provider. The Provider Handbook shall serve as a source of information regarding GF Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the Provider Handbook shall include the following information:	Intentionally left blank.
4.9.2.1.1 Georgia Families Covered Services;	Yes
4.9.2.1.2 Member eligibility categories;	Yes
4.9.2.1.3 Medical Necessity standards and practice guidelines;	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.9.2.1.4 Role of the PCP;	Yes
4.9.2.1.5 Link to the NCQA and Joint Commission web sites;	Yes
4.9.2.1.5 Role of the Dental Home;	Yes
4.9.2.1.6 Emergency Service responsibilities;	Yes
4.9.2.1.7 Health Check/EPSDT Benefit;	Yes
4.9.2.1.8 Prior Authorization, Pre-Certification, and Referral procedures;	Yes
4.9.2.1.9 Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Yes
4.9.2.1.10 Physical Health and Behavioral Health Coordination including the requirement for Behavioral Health Providers to send status reports to PCPs and PCPs to send status reports to Member's Behavioral Health Providers;	Yes
4.9.2.1.11 Provider Complaint System Policies and Procedures, including, but not be limited to, specific instructions for contacting the Contractor's Provider services to file a complaint and which individual(s) have the authority to review a complaint;	Yes
4.9.2.1.12 Policies and procedures for the Provider Grievance and Appeals process;	Yes
4.9.2.1.13 Information on the Member Grievance System, including the Member's right to a State Administrative Law Hearing, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the right to request continuation of Benefits while utilizing the Grievance System;	Yes
4.9.2.1.14 The role of the CVO and link to the CVO web site;	Yes
4.9.2.1.15 Information about the GaHIN including how information will be used by the CMOs and DCH and an explanation of any service limitations or exclusions from coverage;	Yes
4.9.2.1.16 Link to the DCH web site;	Yes
4.9.2.1.17 Role of the DCH fiscal agent and link to the fiscal Agent's web site;	Yes
4.9.2.1.18 Information about the Georgia Families Value-based Purchasing;	Yes
4.9.2.1.19 Transition of Care Planning;	Yes
4.9.2.1.20 Care Coordination Policies;	Yes
4.9.2.1.21 Protocol for Encounter Claims element reporting/records;	Yes
4.9.2.1.22 Medical Records standards;	Yes
4.9.2.1.23 Claims submission protocols and standards, including instructions and all information necessary for a clean or complete Claim;	Yes
4.9.2.1.24 Payment policies;	Yes
4.9.2.1.25 The Contractor's Cultural Competency Plan;	Yes
4.9.2.1.26 Member rights and responsibilities;	Yes
4.9.2.1.27 Other Provider or Subcontractor responsibilities.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	supported that these functions are occurring.

Quality Management

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.12.1.1 The Contractor shall provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s).	Yes
4.12.1.2 The Contractor shall seek input from, and work with, Members, Providers, community resources and agencies to actively improve the Quality of care provided to Members.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.12.1.3.1 The Contractor shall obtain National Committee for Quality Assurance (NCQA) Interim Status by the Operational Start Date. Contractors shall apply for NCQA accreditation, or at other times as required by DCH as follows: 4.12.1.3.1.1 July 1, 2016: Apply for NCQA Interim Status 4.12.1.3.1.2 July 1, 2017: Apply for provisional status (first survey) 4.12.1.3.1.3 December 31, 2017: Notify NCQA of intent to submit data 4.12.1.3.1.4 June 15, 2018: Submit CY 2017 data	Yes
4.12.1.3.2 The Contractor shall achieve NCQA Commendable or Excellent accreditation status within three (3) years after the Operational Start Date. Contractors that lose NCQA Commendable or Excellent status must regain the status within one (1) year.	Yes
4.12.1.4.1 The Contractor shall establish a multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities. This committee shall meet at least quarterly, but more often if warranted. The formal organizational structure must include at a minimum, the following: 4.12.1.4.1.1 A designated health care practitioner, qualified by training and experience, to serve as the QM Director; 4.12.1.4.1.2 A committee which includes representatives from the provider groups as well as clinical and non-clinical areas of the organization; 4.12.1.4.1.3 A senior executive who is responsible for program	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
implementation; 4.12.1.4.1.4 Substantial involvement in QM activities by the Contractor's Medical Director; and 4.12.1.4.1.5 Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.	
4.12.1.4.2 The Quality Management Committee must: 4.12.1.4.2.1 Maintain Records that document the committee's activities, findings, recommendations, actions, and results; and 4.12.1.4.2.2 Obtain DCH's approval of membership of the Quality Oversight Committee.	Yes
4.12.2.1 The Contractor shall support and comply with the Georgia Families DCH Quality Strategic Plan. The Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to Georgia Families and Georgia Families 360 Members (as defined in Title 42 of the Code of Federal Regulations (42 CFR) 431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 CFR 438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 CFR Part 164 (HIPAA Privacy Requirements).	No. There was no specific reference to this section of the contract in the submitted policy documents.
4.12.2.2 The DCH Quality Strategic Plan promotes improvement in the Quality of care provided to enrolled Members through established processes. DCH staff within the Performance, Quality and Outcomes Unit is responsible for oversight of the Contractor's Quality program including:	
4.12.2.2.1 Monitoring and evaluating the Contractor's service delivery system and Provider network, as well as its own processes for Quality management and performance improvement; 4.12.2.2.2 Implementing action plans and activities to correct deficiencies and/or increase the Quality of care provided to enrolled Members; 4.12.2.2.3 Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, Provider profiling, Utilization Management reviews, etc.; 4.12.2.2.4 Monitoring compliance with Federal, State and DCH requirements; 4.12.2.2.5 Ensuring the Contractor's coordination with State registries; 4.12.2.2.6 Ensuring Contractor executive and management staff participation in the quality management and performance improvement processes; 4.12.2.2.7 Ensuring that the development and implementation of Quality management and performance improvement activities include Provider participation and information provided by Members, their families and guardians; and 4.12.2.2.8 Identifying the Contractor's best practices, lessons learned and other findings for performance and Quality improvement.	Yes
4.12.3.1 The Contractor shall comply with the GF DCH Quality Strategic Plan requirements to improve the health outcomes for all GF Members. Improved health outcomes will be documented using established performance measures. DCH uses the CMS issued CHIPRA Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Effectiveness Data and Information Set (HEDIS®) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the quality and health improvement performance measures. DCH will monitor Performance Measure and incent Contractor improvement through the Value-based Purchasing program.	
4.12.3.2 Several of the Adult and Child Core Set measures along with certain other HEDIS® measures utilize hybrid methodology, that is, they require a medical record review in addition to the administrative data requirement for measurement reporting. The number of required record reviews is determined by the specifications for each hybrid measure.	Yes
4.12.3.3 DCH establishes Performance Measure Targets for each measure. It is important that the Contractor continually improve health outcomes from year to year. The performance measure targets, as amended from time to time, for each performance measure can be accessed at http://dch.georgia.gov/medicaid-quality-reporting. Performance targets are based on national Medicaid Managed Care HEDIS® percentiles as reported by NCQA or other benchmarks as established by DCH.	Yes
4.12.3.4 DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CA or PA form must be received by DCH within thirty (30) Calendar Days of receipt of notification of lack of achievement of performance targets. The CA or PA response must be approved by DCH prior to implementation. DCH may conduct follow up on-site reviews to verify compliance with a CA or PA response. DCH may assess Liquidated Damages on Contractors who do not meet the performance measure targets for any one performance measure.	Yes
4.12.3.5 The performance measures apply to the Member populations as specified by the measures' technical specifications. Contractor performance is evaluated annually on the reported rate for each measure. Performance Measures, benchmarks, and/or specifications may change annually to comply with industry standards and updates.	Yes
4.12.3.6 The Contractor must provide for an independent Validation of each performance measure rate and submit the validated results to DCH no later than June 30 of each year.	No. There was no specific reference to this section of the contract in the submitted policy documents.

Third-Party Liability and Coordination of Benefits

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
8.4.1 Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the Health Care expenses of the Member.	Yes
8.4.1.1 Pursuant to Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, DCH hereby authorizes the Contractor as its Agent to identify and cost avoid Claims for all CMO Members, including Peach Care for Kids® Members.	Yes
8.4.1.2 The Contractor shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CMO Members. To the extent permitted by State and federal law, the Contractor shall use Cost Avoidance processes to ensure that primary payments from the liable third party are identified, as specified below in Section 8.4.2.	Yes
8.4.1.3 If the Contractor is unsuccessful in obtaining necessary cooperation from a Member to identify potential Third Party Resources after sixty (60) Calendar Days of such efforts, the Contractor may inform DCH, in a format to be determined by DCH, that efforts have been unsuccessful.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
8.4.1.4 For situations other than Medicare payments where payment is already made to the Provider by the CMO, the CMO shall coordinate with the other responsible payer and shall not recoup funds directly from the Provider and cause the Provider to have to resubmit claims to the other responsible payer.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
8.4.2.1 The Contractor shall cost avoid all Claims or services that are subject to payment from a third party health insurance carrier, and may deny a service to a Member if the Contractor is assured that the third party health insurance carrier will provide the service, with the exception of those situations described below in Section 8.4.2.2. However, if a third party health insurance carrier requires the Member to pay any cost sharing amounts (e.g., co-payment, coinsurance, deductible), the Contractor shall pay the cost sharing amounts. The Contractor's liability for such cost sharing amounts shall not exceed the amount the Contractor would have paid under the Contractor's payment schedule for the service.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
8.4.2.2 Further, the Contractor shall not withhold payment for services provided to a Member if third party liability, or the amount of third party liability, cannot be determined, or if payment will not be available within sixty (60) Calendar Days.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	supported that these functions are occurring.
8.4.2.3 The requirement of Cost Avoidance applies to all Covered Services except Claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services, the Contractor shall ensure that services are provided without regard to insurance payment issues and must provide the service first. The Contractor shall then coordinate with DCH or its Agent to enable DCH to recover payment from the potentially liable third party.	Yes
8.4.2.4 If the Contractor determines that third party liability exists for part or all of the services rendered, the Contractor may:	Intentionally left blank.
8.4.2.4.1 Pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider; and	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
8.4.2.4.2 Pay the Provider only the amount, if any, by which the Provider's allowable Claim exceeds the amount of third party liability.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
8.4.2.5 If the provider determines that a person other than the Contractor to which it has submitted a Claim is responsible for coverage of the Member at the time the service was rendered, the provider may submit the claim to the person that is responsible and that person shall reimburse all Medically Necessary Services without application of any penalty for failure to file claims in a time manner, for failure to obtain Prior Authorization, or for the provider not being a participating provider in the person's network, and the amount of reimbursement shall be that person's applicable rate for the service if the provider is under contract with that person or the rate paid by the DCH for the same type of claim that it pays directly if the provider is not under contract with that person.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.

Utilization Management

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.11.1.1 The Contractor shall implement innovative and effective Utilization Management processes to ensure a high quality, clinically appropriate yet highly efficient and cost effective delivery system. The Contractor shall continually evaluate the cost and Quality of medical services provided by Providers and identify the potential under and over-utilization of clinical services. The Contractor must apply objective and evidence-based criteria that take the individual Member's circumstances and the local delivery system into account when determining the medical appropriateness of Health Care services.	Yes
4.11.1.2 The Contractor shall enable Pre-Certification of service requests when required and direct providers in making appropriate clinical decisions for the Member in the right setting and at the right time. As part of its regular processes for conducting Utilization Review, the Contractor must evaluate all review requests for Medical Necessity and make recommendations that are more appropriate and more cost-effective. The Contractor should leverage findings from current federal efforts around comparative effectiveness research to support its evaluation of requests.	Yes
4.11.1.3 The Contractor shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion. Specifically, the Contractor shall have written Utilization Management Policies and Procedures that:	Intentionally left blank.
4.11.1.3.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.	Yes
4.11.1.3.2 Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.	Yes
4.11.1.3.3 Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.	Yes
4.11.1.3.4 Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition as stated in Sections 1.4 and 4.5.4.	Yes
4.11.1.3.5 Provide for the appeal by Members, or their representative, of authorization decisions, and guarantee no retaliation will be taken by the Contractor against the Member for exercising that right.	Yes
4.11.1.4 The Contractor shall submit the Utilization Management Policies and Procedures to DCH for review and prior approval annually and as changed. Nothing in this Section shall prohibit or impede the Contractor from applying a person-centric clinical decision that may vary from the written Utilization	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Management Policies and Procedures insofar as that decision is accompanied by the clinical rationale for such a decision.	
4.11.1.5 Network Providers may participate in Utilization Review activities to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures shall define when such a conflict may exist and shall describe the remedy.	Yes
4.11.1.5.1.1 The Contractor shall establish a Utilization Management Committee. The Utilization Management Committee is accountable to the Medical Director and governing body of the Contractor. The Utilization Management Committee shall meet no less frequently than a quarterly basis and maintain records of activities, findings, recommendations, and actions. Reports of these activities shall be made available to DCH upon request.	Yes
4.11.1.5.2.1 Emergency Room (ER) Diversion Pilot The Contractor shall develop and implement an ER diversion pilot program with hospital(s) that agree to participate to reduce inappropriate utilization of ERs for non-emergent conditions. The Contractor shall submit to DCH ninety (90) Calendar Days prior to beginning the ER Diversion Pilot program a detailed plan describing how the Contractor will work with providers to reduce inappropriate utilization of ERs for non-emergent conditions. The diversion pilot shall not prohibit or delay a Member's access to ER services.	Yes

Program Integrity Oversight

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.13.1.1 The Contractor shall have a Program Integrity Program, including a mandatory compliance plan, designed to guard against Fraud and Abuse. This Program Integrity Program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of Fraud, Waste and Abuse in the administration and delivery of services under this Contract.	Yes
4.13.1.2 The Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program described below.	Yes
4.13.1.3 The Contractor shall provide DCH with a copy of any Program Integrity settlement agreement entered into with a Provider including the settlement amount and Provider type within seven (7) Business Days of the settlement.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, per AGP the SIU acknowledges this requirement and will supply settlement agreements the SIU negotiates with providers as described in the contract.

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	For settlements occurring in Claims or other departments, ask the PCO.
4.13.2.1 The Contractor's compliance plan shall include, at a minimum, the following:	Intentionally left blank.
4.13.2.1.1 The designation of a Compliance Officer who is accountable to the Contractor's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Contractor's staff, and between the Compliance Officer and DCH staff, are followed.	Yes
4.13.2.1.2 Provision for internal monitoring and auditing of reported Fraud , Waste and Abuse violations, including specific methodologies for such monitoring and auditing;	Yes
4.13.2.1.3 Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste and Abuse compliance plan;	Yes
4.13.2.1.4 Policies to establish a compliance committee that meets quarterly and reviews Fraud, Waste and Abuse compliance issues;	Yes
4.13.2.1.5 Policies to ensure that any individual who reports CMO violations or suspected Fraud, Waste and Abuse will not be retaliated against;	Yes
4.13.2.1.6 Policies of enforcement of standards through well-publicized disciplinary standards;	Yes
4.13.2.1.7 Provision of a data system, resources and staff to perform the Fraud, Waste and Abuse and other compliance responsibilities;	Yes
4.13.2.1.8 Procedures for the detection of Fraud, Waste and Abuse that includes, at a minimum, the following: 4.13.2.1.8.1 Prepayment review of claims; 4.13.2.1.8.2 Claims edits; 4.13.2.1.8.3 Post-processing review of Claims; 4.13.2.1.8.4 Provider profiling; 4.13.2.1.8.5 Quality Control; and 4.13.2.1.8.6 Utilization Management.	Yes
4.13.2.1.9 Written standards for organizational conduct;	Yes
4.13.2.1.10 Effective training and education for the Compliance Officer and the organization's employees, management, board Members, and Subcontractors;	Yes
4.13.2.1.11 Inclusion of information about Fraud, Waste and Abuse identification and reporting in Provider and Member materials;	Yes
4.13.2.1.12 Provisions for the investigation, corrective action and follow-up of any suspected Fraud, Waste and Abuse reports;	Yes
4.13.2.1.13 Procedures for notification to DCH Office of the Inspector General requesting permission before initiating an investigation, notifying a provider of the outcome of an investigation, and/or recovery of any overpayments identified; and	No. There was no specific reference to this section of the contract in the submitted policy documents; however, per AGP the SIU acknowledges this

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
	requirement and will fulfill per contract. For overpayment recoveries perform by other departments outside the SIU, contact the program integrity manager.
4.13.2.1.14 Procedures for reporting suspected Fraud, Waste and Abuse cases to the Georgia Medicaid Fraud Control Unit, through the State Program Integrity Unit, including timelines and use of State approved forms.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, per AGP the SIU acknowledges this requirement and will fulfill per contract using state approved forms and submitting timely.
4.13.2.2 As part of the Program Integrity Program, the Contractor may implement a pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH for review and approval as part of the Program Integrity Policies and Procedures described in Section 4.13.1.	Yes
4.13.2.2.1 Allow Members to change pharmacies for good cause, as determined by the Contractor after discussion with the Provider(s) and the pharmacist. Valid reasons for change should include recipient relocation or the pharmacy does not provide the prescribed drug;	Yes
4.13.2.2.2 Provide Case Management and education reinforcement of appropriate medication use;	Yes
4.13.2.2.3 Annually assess the need for lock in for each Member;	Yes
4.13.2.2.4 Require that the Contractor's Compliance Officer report on the program on a monthly basis to DCH; and	Yes
4.13.2.2.5 Not allow a Member to transfer to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program.	Yes
4.13.3.1 The Contractor shall cooperate and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud, Waste and Abuse cases, including permitting access to the Contractor's place of business during normal business hours, providing requested information, permitting access to personnel, financial and Medical Records, and providing internal reports of investigative, corrective and legal actions taken relative to the suspected case of Fraud and Abuse.	Yes
4.13.3.2 The Contractor's Compliance Officer shall work closely, including attending quarterly meetings, with DCH's program integrity staff to ensure that the activities of one entity do not interfere with an ongoing investigation being conducted by the other entity.	Yes
4.13.3.3 The Contractor shall inform DCH immediately about known or suspected fraud cases and it shall not investigate or resolve the suspicion	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
without making DCH aware of, and if appropriate involved in, the investigation, as determined by DCH.	
4.13.4.1 The Contractor shall submit to DCH a quarterly Fraud and Abuse Report, as described in the RADs, as amended from time to time, and expressly incorporated by reference into the Contract as if completely restated herein. This Report shall include information on the pharmacy lock-in program described in Section 4.13.2.2. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended described in Section 33.20.	Yes

Subcontractor Oversight

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
18.1.1 The Contractor will not subcontract or permit anyone other than Contractor personnel to perform any of the work, services, or other performance required of the Contractor under this Contract, or assign any of its rights or obligations hereunder, without the prior written consent of DCH. Prior to hiring or entering into an agreement with any Subcontractor, any and all Subcontractors and Subcontracts shall be approved by DCH. DCH must also approve any replacement Subcontractors in the same manner. Upon request from DCH, the Contractor shall provide in writing the names of all proposed or actual Subcontractors. DCH reserves the right to reject any or all Subcontractors that, in the judgment of DCH, lack the skill, experience, or record of satisfactory performance to perform the work specified herein.	Yes
18.1.2 Contractor is solely responsible for all work contemplated and required by this Contract, whether Contractor performs the work directly or through a Subcontractor. No subcontract will be approved which would relieve Contractor or its sureties of their responsibilities under this Contract. In addition, DCH reserves the right to terminate this Contract if Contractor fails to notify DCH in accordance with the terms of this paragraph.	Yes
18.1.3 All contracts between the Contractor and Subcontractors must be in writing and must specify the activities and responsibilities delegated to the Subcontractor. The contracts must also include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. DCH reserves the right to inspect all subcontract agreements at any time during the Contract period.	Yes
18.1.4 All contracts entered into between Contractor and any Subcontractor related to this Contract must contain provisions which require Contractor to monitor the Subcontractor's performance on an ongoing basis and subject the Subcontractor to formal review according to a schedule established by DCH and consistent with industry standards or State laws and regulations. Contractor shall identify any deficiencies or areas for improvement related to any Subcontractor's performance related to this Contract, and upon request	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
from DCH, provide evidence that corrective action has been taken to address the deficiency.	
18.1.5 For any subcontract, there must be a designated project manager who is a member of the Subcontractor's staff that is directly accessible by the State. This individual's name and contact information must be provided to the State when the subcontract is executed. The subcontract agreement must contain a provision which requires the Contractor and its Subcontractors to seek binding arbitration to resolve any dispute between those parties and to provide DCH with written notice of the dispute.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, according to AGP, DCH has not historically enforced AMGP providing a "direct" contact at each delegated Subcontractor. DCH has always communicated with AMGP staff who engage the Vendor/Subcontractor managers who oversee the Vendors and work directly with the Vendor staff. If DCH does want to speak with Vendor staff, AMGP arranges a meeting to include DCH, AMGP and Vendor staff as applicable.
18.1.6 Contractor shall give DCH immediate notice in writing by registered mail or certified mail of any action or suit filed by any Subcontractor and prompt notice of any Claim made against the Contractor by any Subcontractor or vendor that, in the opinion of Contractor, may result in litigation related in any way to this Contract.	Yes
18.1.7 All Subcontractors must fulfill the requirements of 42 CFR 438.6 as appropriate.	Yes
18.1.8 All Provider contracts shall comply with the requirements and provisions as set forth in Section 4.10 of this Contract.	Yes
18.1.9 The Contractor shall submit a Subcontractor Information and Monitoring Report to include, but is not limited to: Subcontractor name, services provided, effective date of the subcontracted agreement.	Yes
18.1.10 The Contractor shall submit to DCH a written notification of any subcontractor terminations at least ninety (90) days prior to the effective date of the termination.	Yes

Encounter Submissions

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.16.3.1 The GF program utilizes Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Contractor to provide timely, complete and accurate information. Encounter data from the Contractor also allows DCH to budget available resources, set Contractor Capitation Rates, monitor Utilization, follow public health trends and detect potential Fraud. Most importantly, it allows DCH to make recommendations that can lead to the improvement of Health Care outcomes.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.16.3.2 The Contractor shall work with all contracted Providers to implement standardized billing requirements to enhance the Quality and accuracy of the billing data submitted to the health plan.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.16.3.3 The Contractor shall instruct contracted Providers that the State of Georgia Medicaid ID number is mandatory, until such time as otherwise determined by DCH. The Contractor will emphasize to Providers the need for a unique State of Georgia Medicaid ID Number for each practice location unless otherwise determined by DCH.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.16.3.4 The Contractor shall submit to DCH's FAC and Data Warehouse vendor weekly cycles of data files. All identified errors shall be submitted to the Contractor from the FAC each Week. The Contractor shall address identified issues and resubmit the corrected file to the FAC within seven (7) Business Days of receipt. Data files to the DCH Data Warehouse vendor may lag a week based on corrected file re-submissions identified by DCH's Fiscal Agent Supplier.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.16.3.5 The Contractor is required to submit one hundred percent (100%) of Critical Data Elements such as state Medicaid ID numbers, National Provider Identification (NPI) numbers, SSN numbers, Member Name, and DOB. These items must match the State's eligibility and Provider file.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.16.3.6 The Contractor's submitted Claims must consistently include valid values for the below list of fields and any other fields identified by DCH: 4.16.3.6.1 Patient name 4.16.3.6.2 Date of birth 4.16.3.6.3 Place of service 4.16.3.6.3 Date of service	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.16.3.6.4 Type of service 4.16.3.6.5 Units of service 4.16.3.6.7 Diagnostic related groupings (DRGs) 4.16.3.6.8 Treating Provider 4.16.3.6.9 NPI number of rendering Provider 4.16.3.6.10 NPI number of OPR Provider 4.16.3.6.11 Tax Identification Number 4.16.3.6.12 Facility code 4.16.3.6.13 A unique Transaction Control Number (TCN) 4.16.3.6.14 All additionally required CMS 1500 or UB 04 codes 4.16.3.6.15 CMO Paid Amount 4.16.3.6.16. DRG version 4.16.3.6.17. Specify units (by adding allowed units; billed units and paid units of service 4.16.3.6.18 Mandatory Identification of any claim that is a 340B claim.	supported that these functions are occurring.
4.16.3.7 For each submission of Claims as described in this section, the Contractor must provide via DCH's required electronic format the following Cash Disbursements data elements: 4.16.3.7.1 Provider/Payee Number 4.16.3.7.2 Name 4.16.3.7.3 Address 4.16.3.7.4 City 4.16.3.7.5 State 4.16.3.7.6 Zip 4.16.3.7.8 Check date 4.16.3.7.9 Check number 4.16.3.7.10 Check amount 4.16.3.7.11 Check code (i.e. EFT, paper check, etc.).	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.16.3.8 The Contractor will assist DCH in reconciliation of Cash Disbursement check amount totals to CMO Paid Amount totals for submitted Claims.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.16.3.9 The Contractor shall submit ninety-nine percent (99%) of Encounter Claims within thirty (30) Calendar Days of Claims payment both for the original Claim and any adjustment. DCH will validate Encounter Claims submission according to the cash disbursement journal of the Contractor and any of its applicable subcontractors.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.16.3.10 The Contractor shall maintain an Encounter Error Rate of less than five percent (<5%) weekly as monitored by the FAC and DCH. The Encounter Error Rate is the occurrence of a single error in any TCN or Encounter Claim	No. There was no specific reference to this section of the contract in the submitted policy documents; however,

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
counts as an error for that encounter (this is regardless of how many other errors are detected in the TCN.)	interviews with AGP staff supported that these functions are occurring.
4.16.3.11 The Contractor's failure to comply with the defined standard(s) will be subject to a Corrective Action Plan and the Contractor may be liable for Liquidated Damages.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.
4.16.3.12 Within thirty Calendar Days of Contract Award, the Contractor must submit to DCH a data model of the Supplier's reporting repository, the proposed data layout for weekly data file submissions and a corresponding data dictionary. As these documents are part of DCH's advancement in MITA maturity, such information will not be considered final without DCH approval. Please note that DCH uses the Erwin Data Modeling tool. A sample data dictionary is included in the Suppliers' Library. The sample data dictionary is a guide to provide Suppliers with an understanding of DCH's expectations as it relates to the elements to be included in a dictionary and the format which will be most useful to the DCH. Alternate dictionaries may be accepted if they, at the least, provide the listed elements in a format with similar functionality.	No. There was no specific reference to this section of the contract in the submitted policy documents; however, interviews with AGP staff supported that these functions are occurring.

Appendix D: Georgia Families 360° Policy and Procedure Review

Care Coordination Services

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.11.8.15.1 The Contractor shall implement an approach to coordination that employs person-centered strategies, collaboration with DCH and sister agencies, and does not focus solely on the Member's immediate health care needs. The following approach to person-centered care shall be incorporated into the Contractor's Care Coordination program:	Yes
4.11.8.15.2 The Contractor shall provide Care Coordination services which shall:	Yes
4.11.8.15.2.1 Be comprehensive: All services a Member receives are to be coordinated;	Yes
4.11.8.15.2.2 Be patient-centered: Should meet the needs of Members, addressing both developmental and chronic conditions;	Yes
4.11.8.15.2.3 Include actively linking the Member, in a timely manner, to Providers, medical services, residential, social and other support services or resources appropriate to the needs and goals identified in the plan of care. Care Coordination should ensure that services are delivered appropriately and that information flows among care Providers and back to the PCP;	Yes
4.11.8.15.2.4 Uses the person's own situation and experiences as a starting point based upon information gathered during outreach and Health Risk Assessment activities and the individual's Claims history;	Yes
4.11.8.15.2.5 Strives to understand behaviors, clinical symptoms and clinical, as well as non-clinical, drivers of utilization from the perspective of the person;	Yes
4.11.8.15.2.6 Tailors care and treatment to each individual;	Yes
4.11.8.15.2.7 Promotes both empowerment of the person and shared decision-making;	Yes
4.11.8.15.2.8 Involves the person and/or caregiver as an active, collaborative partner; and	Yes
4.11.8.15.2.9 Strives to involve the person's social network in his/her care.	Yes
4.11.8.15.3 The Contractor's ability to provide rigorous and immediate Care Coordination to meet individual needs of Members will be a key indicator of success. Care planning for Members must begin immediately upon the Contractor's receipt of the eligibility file or electronic notification from DCH, DFCS or DJJ.	Yes
4.11.8.16.1 The Contractor shall use the results of all assessments and screenings to develop a Health Care Service Plan which identified the Member's Care Coordination needs for all new Members within thirty (30) Calendar Days of Member Enrollment. The Contractor must document the	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
involvement of the Member's PCP, dentist, Behavioral Health Providers, specialists or other providers in the development of the Health Care Service Plan and provide evidence of such documentation to DCH, DFCS and DJJ.	
4.11.8.16.2 The Contractor shall develop a process by which the Contractor will regularly review and update the Members' Health Care Service Plans, which shall include:	Yes
4.11.8.16.2.1 The detailed description of the involvement of the Member's PCP, dentist, Behavioral Health Providers, specialists or other providers in the development of the Health Care Service Plan;	Yes
4.11.8.16.2.2 The approach for updating or revising the Health Services Plan; and	Yes
4.11.8.16.2.3 Details on the monitoring and follow-up activities conducted by the Contractor with the Members' Providers.	Yes
4.11.8.16.3 Such process shall be submitted to DCH for review and approval within ninety (90) Calendar Days of the Operational Start Date. DCH shall have at least ten (10) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.	Yes
4.11.8.16.4 The Contractor is responsible for ensuring that the Health Care Service Plan for Members with Severe Emotional Disturbance (SED) shall include a safety and contingency Crisis plan. The development of such a plan will be coordinated between the Contractor, Core Services Providers and/or IFI Providers.	Yes
4.11.8.17.1 All Members will have access to Care Coordination services and an interdisciplinary Care Coordination Team. The Care Coordination Team will include a Care Coordinator and clinical representatives to meet the individual needs of Members. The Care Coordination team will:	Yes
4.11.8.17.1.1 Coordinate with DFCS and DJJ to develop work flows and processes, including those related to the transmission of clinical and non-clinical Member information. These workflows and processes shall be subject to the approval of DCH;	Yes
4.11.8.17.1.2 Provide information to and assist Providers, Members, Foster Parents, Adoptive Parents, Caregivers, DFCS Staff, DJJ, JPPS and Residential Placement Providers with access to care and coordination of services;	Yes
4.11.8.17.1.3 Ensure access to primary, dental and specialty care and support services, including assisting Members, Caregivers, Foster and Adoptive Parents, DFCS staff and DJJ Staff with locating Providers, and scheduling and obtaining appointments as necessary;	Yes
4.11.8.17.1.4 Expedite the scheduling of appointments for Medical Assessments and facilitating Providers' timely submittal of Assessment results used to determine Residential Placements as requested by DFCS and DJJ. The Contractor must give high priority to this function in its Care Coordination operations;	Yes
4.11.8.17.1.5 Compile Assessment results used to determine Residential Placements as requested by DFCS and DJJ and submitting those results to the	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
appropriate DFCS or DJJ entity within the timeframes identified in this Contract;	
4.11.8.17.1.6 Assist with coordinating non-emergent transportation for Members as needed for Provider appointments and other Health Care Services;	Yes
4.11.8.17.1.7 Broker community supports for Members and arrange for referrals to community-based resources as necessary;	Yes
4.11.8.17.1.8 Document efforts to obtain Provider appointments, arrange transportation, establish meaningful contact with the Members' PCP, Dentists, specialists and other Providers, and arrange for referrals to community-based resources. Such documentation shall include details on any barriers or obstacles to obtaining appointments, arranging transportation, establishing meaningful contact with Providers or arranging referrals to community-based resources;	Yes
4.11.8.17.1.9 Provide Members with access to information about the Prior Authorization processes of the Contractor and its business partners;	Yes
4.11.8.17.1.10 Define program requirements and processes, including the Member Appeals processes and how the Contractor will provide assistance to Providers and Members with navigating these processes;	Yes
4.11.8.17.1.11 Educate the Contractor's staff about coordinating with DFCS and DJJ as identified in the Contractor's DFCS and DJJ Communication Plan. The Plan should include, but not be limited to, when medical information is required by DFCS and DJJ and/or is necessary for court hearings;	Yes
4.11.8.17.1.12 Educate Providers about providing medical information to DFCS or DJJ as requested, including but not limited to medical information necessary for court hearings. If the Provider has not timely responded to a DFCS or DJJ request and/or a court's subpoena or request for such information, the Contractor must timely contact the Provider in question to require him or her to provide the requested information. The Contractor shall remind the Provider of his or her legal obligations to produce such information, including those obligations arising out of the Network Provider agreement with the Contractor, including those obligations arising out of the Network Provider agreement with the Contractor;	Yes
4.11.8.17.1.13 Work with PCPs and specialists of prior health plans to ensure continuity of care for Members with Special Health Care Needs (MSHCN) receiving services authorized in a treatment plan by their prior health plan, to address issues that will help the Member's condition remain stable and services are consistent to meet the Member's ongoing needs; and	Yes
4.11.8.17.1.14 Provide application assistance to MSHCN who may qualify for Supplemental Security Income (SSI) benefits.	Yes
4.11.8.17.2 The Care Coordinator will ensure the Care Coordination Team has the information it needs to make timely and appropriate authorizations and referrals to meet Member needs. This includes, but is not limited to, contacting prior health plans and Providers for information the Care Coordination Team may need to work with current Providers to develop treatment plans. The Care	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Coordinator will ensure that approved care plans and authorizations are communicated timely to treating Providers, DFCS, DJJ and other agencies as required, whether via the Virtual Health Record (VHR) or by direct communications. The Care Coordinator will ensure that Members, Providers, Caregivers, Foster and Adoptive Parents, DFCS, DJJ, Residential Placement Providers and other agencies also have the most current information regarding community resources available to assist Members with meeting their needs and assist Members with connecting with these resources.	
4.11.8.17.3 The Care Coordination Teams must include an interdisciplinary group of professionals identified specifically to meet the needs of each individual Member.	Yes
4.11.8.17.4 Based on information identified through required assessments, the Contractor shall stratify Members according to their risk(s), costs and impactability. The level of intensity of Care Management services provided by Care Coordination Teams must be tailored in intensity to meet the needs of each individual Member as identified in section 1.4. Members may receive the following level of Care Management services:	Yes
4.11.8.17.5 Care Management services;	Yes
4.11.8.17.6 Intensive Care Coordination, which must include the following monthly contacts:	Yes
4.11.8.17.6.1 One (1) Face-to-face visit;	Yes
4.11.8.17.6.2 One (1) weekly contact;	Yes
4.11.8.17.6.3 One (1) Child and Family Team Meeting; and	Yes
4.11.8.17.6.4 One (1) care plan update.	Yes
4.11.8.17.7 Complex Care Coordination including Members with a previous Mental Health inpatient stay or an inpatient stay for a psychosocial disorder and Members with Special Health Care Needs. Care Coordinators must provide the following monthly contacts to Members receiving Complex Care Coordination:	Yes
4.11.8.17.7.1 Two (2) face-to-face visits;	Yes
4.11.8.17.7.2 One (1) weekly contact;	Yes
4.11.8.17.7.3 A minimum of two (2) hours per week Care Coordination;	Yes
4.11.8.17.7.4 One (1) Child and Family Team Meeting; and	Yes
4.11.8.17.7.5 One (1) health care service plan update.	Yes
4.11.8.18 Members identified as needing Complex Care Coordination services due to Behavioral Health needs must receive Care Coordination services provided by Coordinators who have been certified and trained in the delivery of High Fidelity Wrap Around Care. The Contractor shall include a Nurse Case Manager (NCM) to assist Members identified through the health assessment as Members with Special Health Care Needs. The NCM will help Members with Special Health Care Needs obtain Medically Necessary care, health related services and coordinate clinical care needs with holistic consideration. The Contractor's NCM must coordinate across a Member's Providers and health systems. The Contractor must have a process to facilitate, maintain and	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
coordinate both care and communication with State agency staff, Providers, Caregivers, Foster or Adoptive Parents, Service Providers, and Members.	
4.11.9.1 The Contractor shall coordinate and work collaboratively with all divisions within DCH, as well as with other State agencies, and with other CMOs for administration of the GF 360º program.	Yes
4.11.9.2 The Contractor shall also coordinate with Local Education Agencies (LEAs) in the Referral and provision of Children's Intervention School Services provided by the LEAs to ensure Medical Necessity and prevent duplication of services.	Yes
4.11.9.3 The Contractor shall coordinate the services furnished to its Members with the services the Member receives outside the CMO, including services received through any other managed care entity.	Yes
4.11.9.4 The Contractor shall coordinate with all DCH-contracted entities involved in providing care to the Member or administering program services that also impact the CMO's services. Coordination with other contracted-entities includes, but is not limited to, the following:	Yes
4.11.9.4.1 NET vendors to ensure Members are able to access Medically Necessary services in a timely manner.	Yes
4.11.9.4.2 DCH's Pharmacy Rebate Services Vendor for the purposes of processing pharmacy rebates. The Contractor shall regularly submit data, such as Omnibus Budget Reconciliation Act (OBRA) and J-Code claims feed to the Fee-for-Service Pharmacy Rebate Services Vendor. Prior to program launch, the Contractor will accept the Fee-for-Service Pharmacy Rebate Services Vendor's file format for data feeds and for testing interface capabilities. The Contractor shall respond to and resolve all inquiries and requests from the Pharmacy Rebate Vendor within thirty (30) Calendar Days of receipt of such inquiry or request.	Yes
4.11.9.4.3 DCH's CVO as set forth in Section 4.8.21.	Yes
4.11.9.4.4 DCH's FAC.	Yes
4.11.9.4.5 The State Health Benefit Plan	Yes
4.11.9.4.6 Vendors identified by DCH to complete DCH required audits, reviews and special projects.	Yes
4.11.9.4.7 Other DCH vendors to complete statewide initiatives.	Yes
4.11.9.4.8 Private insurance and Fee-for-Service providers.	Yes
4.11.9.5 The Contractor shall implement procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR 160 and 45 CFR 164.	Yes
4.11.9.6 The Contractor shall implement a systematic administrative process to coordinate with DFCS, including providing DFCS with requested information and coordinating with PCPs or specialists for medical information when required by DFCS and/or necessary for court hearings for FC Members. A coordination plan shall be due within one hundred fifty (150) Calendar Days prior to the Operational Start Date. DCH shall have at least fourteen (14) Calendar Days to review the materials and the Contractor shall have five (5)	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.	
4.11.9.7 The Contractor shall implement a systematic administrative process to coordinate with DJJ, including providing DJJ with requested information and coordinating with PCPs or specialists for medical information when required by DJJ and/or necessary for court hearings for DJJ Members. A DJJ coordination plan shall be due within one hundred fifty (150) Calendar Days prior to the Operational Start Date. DCH shall have at least fourteen (14) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.	Yes
4.11.9.8 The Contractor shall have documented Member Care Coordination policies and procedures for coordinating care and creating linkages with external organizations, including but not limited to school districts, child protective service agencies, early intervention agencies, behavioral health, and developmental disabilities service organizations. Such policies and procedures must include details on the Contractor's approach for documenting care coordination activities and creating linkages with external organizations for each Member. The Contractor shall submit the policies and procedures to DCH for review within one hundred twenty (120) Calendar Days of the Operational Start Date and within ten (10) Calendar Days of any subsequent updates. In all instances, DCH shall have at least fourteen (14) Calendar Days to review the materials and the Contractor shall have five (5) Calendar Days from the completion of DCH's review to submit the finalized materials to DCH.	Yes

Member Enrollment and Disenrollment

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.1.1.1. DCH or its Agent is responsible for Enrollment, including Disenrollment for Members, education on enrollment options, and outreach activities. The Contractor shall coordinate with DCH and its Agent as necessary for all Enrollment and Disenrollment for Member functions.	Yes
4.1.1.2 DCH or its Agent will make every effort to ensure that individuals who are ineligible for Enrollment are not enrolled in GF 360º. However, to ensure that such individuals are not enrolled in GF 360º, the Contractor shall assist DCH or its Agent in the identification of individuals who are ineligible for Enrollment in GF 360º, as set forth in Section 1.2.3, should such individuals inadvertently become enrolled in GF 360º.	Yes
4.1.1.3 The Contractor shall assist DCH or its Agent in the identification of individuals that become ineligible for Medicaid, PeachCare for Kids® and P4HB (for example, those who have died, been incarcerated, or moved out-of-state).	Yes
4.1.1.4 The Contractor shall accept all eligible individuals for Enrollment as identified by DCH or its Agent without restrictions. The Contractor shall not discriminate against individuals on any basis, including but not limited to	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
religion, gender, race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on any basis, including but not limited to religion, gender, race, color, or national origin or on the basis of health, health status, pre-existing Condition, or need for Health Care services.	
4.1.1.5 The Contractor shall enroll Members in the GF 360º program and immediately begin Care Coordination upon the receipt of an electronic notification from DCH, DFCS or DJJ stating that the Member is eligible for the GF 360º program.	Yes
4.2.1.1 AA Members enrolled in GF 360º may elect to disenroll from the program without cause during the AA Member Fee-for-Service Selection Period. AA Members disenrolling from the Contractor's GF 360º Plan shall return to the Medicaid Fee-For-Service delivery system. AA Members may disenroll from the CMO for cause at any time and return to the Medicaid Fee-for-Service delivery system. An AA Member may request Disenrollment without cause during the ninety (90) Calendar Days following the date of the Member's initial Enrollment with the CMO or the date DCH or its Agent sends the Member notice of the Enrollment, whichever is later. An AA Member may request Disenrollment without cause every twelve (12) months thereafter.	Yes
4.2.1.2 AA Members may request Disenrollment from the CMO for cause at any time.	Yes
4.2.1.3 The Contractor shall provide assistance to Members seeking to disenroll. This assistance shall consist of providing Disenrollment forms to the Member and referring the Member to DCH or its Agent who will make Disenrollment determinations.	Yes
4.2.2.1 The Contractor shall complete all Disenrollment paperwork for Members it is seeking to disenroll.	Yes
4.2.2.2 The Contractor shall notify DCH or its Agent upon identification of a Member who it knows or believes meets the criteria for Disenrollment as defined in Section 4.2.2.2.	Yes

Internal Grievances and Appeals

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.14.1.1 The Contractor's Grievance System shall include a process to receive, track, resolve and report on Grievances from its Members. The Contractor's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Contractor's Appeals Process shall include an internal process that must be exhausted by the Member prior to accessing an Administrative Law Hearing. See O.C.G.A. §49-4-153.	Yes
4.14.1.2 The Contractor shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Contractor's policies and procedures	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
shall be available in the Member's primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for initial review and approval, and as updated thereafter.	
4.14.1.3 The Contractor shall process each Grievance and Administrative Review using applicable State and federal laws and regulations, the provisions of this Contract, and the Contractor's written policies and procedures as approved by DCH. Pertinent facts from all parties must be collected during the investigation.	Yes
4.14.1.4 The Contractor shall give Members any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.	Yes
4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance and Appeal resolutions.	Yes
4.14.1.6 The Contractor shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision-making; and are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease if deciding any of the following:	Yes
4.14.1.6.1 An Appeal of a denial that is based on lack of Medical Necessity;	Yes
4.14.1.6.2 A Grievance regarding denial of expedited resolutions of an Administrative Review; and	Yes
4.14.1.6.3 Any Grievance or Administrative Review that involves clinical issues.	Yes
4.14.3.1 A Member or Member's Authorized Representative may file a Grievance to the Contractor either orally or in writing. A Grievance may be filed about any matter other than a Proposed Action. A Provider cannot file a Grievance on behalf of a Member.	Yes
4.14.3.2 The Contractor shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals, under the supervision of the Contractor's Medical Director who have the appropriate clinical expertise, as determined by DCH, in treating the Member's Condition or disease and who were not involved in any previous level of review or decision making	Yes
4.14.3.3 The Contractor shall acknowledge receipt of each filed Grievance in writing within ten (10) Calendar days of receipt. The Contractor shall have procedures in place to notify all Members in their primary language of Grievance resolutions.	Yes
4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.	Yes
4.14.2.1 DCH also allows a state review on behalf of PeachCare for Kids® Members. If the Member, parent or other authorized representative of the	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Member believes that a denied service should be covered, the parent or such representative must send a written request for review to the Contractor.	
4.14.2.2 If the decision of the Contractor review maintains the denial of service, a letter will be sent to the parent or representative detailing the reason for denial. If the parent or representative elects to dispute the decision, the parent or representative will have the option of having the decision reviewed by the Formal Grievance Committee. The request should be sent to: Department of Community Health PeachCare for Kids® Administrative Review Request 2 Peachtree Street, NW, 37th floor Atlanta, GA 30303-3159	Yes
4.14.2.3 The decision of the Formal Grievance Committee will be the final recourse available to the Member.	Yes
4.14.4.1 All Proposed Actions shall be made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the Member's Condition or disease.	Yes
4.14.4.2 In the event of a Proposed Action, the Contractor shall notify the Member in writing. The Contractor shall also provide written notice of a Proposed Action to the Provider. This notice must meet the language and format requirements in accordance with Section 4.3.2 of this Contract and be sent in accordance with the timeframes described in Section 4.14.3.4.	Yes
4.14.4.5.1 The Contractor may shorten the period of advance notice to five (5) Calendar Days before date of Action if the Contractor has facts indicating that Action should be taken because of probable Member Fraud and the facts have been verified, if possible, through secondary sources.	Yes
4.14.5.1 An Administrative Review is the request for review of a "Proposed Action". The Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, may file an Administrative Review either orally or in writing. Unless the Member or Provider requests expedited review, the Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's or written consent, must follow an oral filing with a written, signed, request for Administrative Review.	Yes
4.14.6.1 If the Contractor upholds the Proposed Action in response to an Administrative Review filed by the Member the Contractor shall issue a Notice of Adverse Action within the timeframes described in Sections 4.14.5.8 and 4.14.5.9.	Yes
4.14.7.1 The State will maintain an independent Administrative Law Hearing process as defined in O.C.G.A. §49-4-153 and as required by federal law, 42 CFR 431.200. The Administrative Law Hearing process shall provide Members an opportunity for a hearing before an	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
impartial Administrative Law Judge. The Contractor shall comply with decisions reached as a result of the Administrative Law Hearing process.	

Member Call Center

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.3.8.1 The Contractor must provide a twenty-four (24) hour call center staffed with experienced personnel familiar with GF 360º, Georgia child-serving agencies and the Georgia provider community.	Yes
4.3.8.2 The Call center must comply with Title IV of the Civil Rights Act. The call center shall be equipped to handle calls from non-English speaking callers, as well as calls from Members who are hearing impaired.	Yes
4.3.8.3 The call center staff shall be trained to accurately assist Members with general inquiries, identify the need for Crisis intervention and provide referrals to Georgia Crisis and Access Line (GCAL) or other appropriate resources for emergency and crisis needs. The Contractor shall work with GCAL to develop Crisis protocols. The Contractor shall submit such protocols to DCH for review and approval no later than ninety (90) Calendar Days of the Operational Start Date. DCH shall have fifteen (15) Calendar Days to review the protocols and the Contractor shall have five (5) Calendar Days from completion of DCH's review to submit the finalized protocols to DCH.	Yes
4.3.8.4 The Contractor must develop appropriate, interactive scripts for call center staff to use during initial welcome calls when making outbound calls to new Members and to respond to Member calls. The Contractor's call center staff must also use a DCH-approved script to respond to Members who call to request assistance with PCP selection. The Contractor must develop special scripts for emergency and unusual situations, as requested by DCH. All scripts must be clear and easily understood. The Contractor must review the scripts annually to determine any necessary revisions. DCH reserves the right to request and review call center scripts at any time. The Contractor's call center job descriptions must detail the level and type of training related to crisis calls, including how personnel are trained to recognize callers in Crisis and then manage triage. The Contractor must have an operational process through which emergency and Crisis calls are prioritized over routine calls, protocols that support warm transfers and technology that enables direct telephonic/computer connectivity to emergent and Crisis intervention resources.	No. Avesis does not utilize call scripts.
4.3.8.5 The Contractor shall develop call center policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.	Yes
4.3.8.6 The Contractor shall submit these call center policies and procedures, including performance standards, to DCH for initial review within sixty (60)	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Calendar Days of the Contract Effective Date and approval, and as updated thereafter.	
4.3.8.7 The Contractor shall fully staff the call center between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The call center staff shall be trained to accurately respond to Member questions in all areas, including, but not limited to, Covered Services, the Provider Network, and Non-Emergency Transportation (NET). Additionally, the Contractor shall have an automated system available between the hours of 7:00 a.m. and 7:00 p.m. EST Monday through Friday and at all hours on weekends and State holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. A Contractor's Representative shall return messages on the next Business Day.	Yes
4.3.8.8 The Contractor shall achieve performance standards and monitor call center performance by recording calls and employing other Monitoring activities. The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Call Center. The Contractor shall submit the Call Center Quality Criteria and Protocols to DCH Provider Services for review and approval annually. At a minimum, the standards shall require that, on a Calendar month basis:	Yes
4.3.8.8.1 Average Speed of Answer: Ninety percent (90%) of calls shall be answered by a person within thirty (30) seconds with the remaining ten percent (10%) answered within an additional thirty (30) seconds by a live operator measured weekly. "Answer" shall mean each caller who elects to speak is connected to a live representative. The caller shall not be placed on hold immediately by the live representative.	Yes
4.3.8.8.2 Abandoned Call Rate of five percent (5%) or less. DCH considers a call to be "abandoned" if the caller elects an option and is either (i) not permitted access to that option, or (ii) the system disconnects the call while the Member is on hold.	Yes
4.3.8.8.3 Blocked Call Rate, or a call that was not allowed into the system, does not exceed one percent (1%).	Yes
4.3.8.8.4 Average Hold Time of less than one (1) minute ninety-nine percent (99%) of the time. Hold time refers to the average length of time callers are placed on hold by a live Call Center Representative.	Yes
4.3.8.8.5 Timely Response to Call Center Phone Inquiries: One hundred percent (100%) of call center open inquiries will be resolved and closed within seventy-two (72) clock hours. DCH will provide the definition of "closed" for this performance measure.	Yes
4.3.8.8.6 Accurate Response to Call Center Phone Inquiries: Call center representatives' accuracy rate must be ninety percent (90%) or higher.	Yes
4.3.8.9 The Contractor shall establish remote phone monitoring capabilities for at least five (5) DCH staff. DCH or its Agent shall be able, using a personal computer and/or phone, to monitor call center and field office calls in progress	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
and to identify the number of call center staff answering calls and the identity of the individual call center staff answering the calls.	

Provider Network

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.8.1.1 The Contractor shall develop and maintain a network of Providers and facilities adequate to deliver Covered Services as described in the RFP and this Contract while ensuring adequate and appropriate provision of services to Members in rural areas which may include the use of telemedicine when appropriate to the condition and needs of the Member. The Contractor is solely responsible for providing a network of physicians, pharmacies, hospitals, physical therapists, occupational therapists, speech therapists, Border Providers and other health care Providers through whom it provides the items and services included in Covered Services.	Yes
4.8.1.2 The Contractor must expand upon its Georgia Families Provider network to meet the unique needs of the Members. The Contractor shall employ innovative solutions for providing access in underserved areas. For example, the Contractor may consider the provision of physical health and behavioral health telemedicine services in local schools. The Provider network must, at a minimum, include the following:	Yes
4.8.1.2.1 Primary care and specialist providers who are trained or experienced in trauma-informed care and in treating individuals with complex special needs, including the population which comprises the Members;	Yes
4.8.1.2.2 Providers who have knowledge and experience in identifying child abuse and neglect;	Yes
4.8.1.2.3 Providers who render Core Services and Intensive Family Intervention (IFI) services;	Yes
4.8.1.2.4 Providers recommended by DCH to ensure network access for Members, including independent behavioral health providers and non-traditional providers. Such providers must meet the State's credentialing requirements.	Yes
4.8.1.3 The Contractor is encouraged to contract with the Community Service Boards to provide Core Services.	Yes
4.8.1.4 Such Providers must meet the GF 360º State's Credentialing requirements.	Yes
4.8.1.4.1 The Contractor is also expected to form productive relationships with provider associations with experience serving the population which comprises the Members.	Yes
4.8.1.4.2 The Contractor shall provide the option for Providers to enroll for the purposes of serving the GF 360º population only rather than the universe of all Medicaid Members associated with all Georgia Families enrollees in the Contractor's plan.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.8.1.5 The Contractor shall include in its network only those Providers that have been appropriately credentialed by DCH or its Agent, that maintain current license(s), and that have appropriate locations to provide the Covered Services.	Yes
4.8.1.6 The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency.	Yes
4.8.1.7 The Contractor shall notify DCH sixty (60) Calendar Days in advance when a decision is made to close network enrollment for new Provider contracts and also notify DCH when network enrollment is reopened. The Contractor must notify DCH sixty (60) Calendar Days prior to closing a Provider panel.	Yes
4.8.1.8 The Contractor shall not include any Providers who have been excluded from participation by the United States Department of Health and Human Services, Office of Inspector General, or who are on the State's list of excluded Providers. The Contractor shall check the exclusions list on a monthly basis and shall immediately terminate any Provider found to be excluded and notify the Member per the requirements outlined in this Contract.	Yes
4.8.2.1 The Contractor shall have written Provider Selection and Retention Policies and Procedures. In selecting and retaining Providers in its network the Contractor shall consider the following:	Yes
4.8.2.1.1 The anticipated GF 360º Enrollment;	Yes
4.8.2.1.2 The expected Utilization of services, taking into consideration the characteristics and Health Care needs of its Members;	Yes
4.8.2.1.3 The numbers and types (in terms of training, experience and specialization) of Providers required to furnish the Covered Services;	Yes
4.8.2.1.4 The numbers of network Providers who are not accepting new GF 360º patients; and	Yes
4.8.2.1.5 The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.	Yes
4.8.2.2 If the Contractor declines to include individual Providers or groups of Providers in its network, the Contractor shall give the affected Providers written notice of the reason(s) for the decision. These provisions shall not be construed to:	Yes
4.8.2.2.1 Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members;	Yes
4.8.2.2.2 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs that are consistent with its responsibilities to Members.	Yes
4.8.2.3 The Contractor shall ensure that all network Providers have knowingly and willfully agreed to participate in the Contractor's network. The Contractor shall not acquire established networks without contacting each individual Provider to ensure knowledge of the requirements of this Contract and the	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
Provider's complete understanding and agreement to fulfill all terms of the Provider Contract, as outlined in Section 4.10. DCH reserves the right to confirm and validate, through both the collection of information and documentation from the Contractor and on-site visits to network Providers, the existence of a direct relationship between the Contractor and the network Providers.	
4.8.2.4 The Contractor shall send all newly contracted Providers a written network participation welcome letter that includes a contract effective date for which Providers are approved to begin providing medical services to Members.	Yes
4.8.2.5 The Contractor shall survey all Providers who chose to exit the network and use the results of Provider exit surveys to improve Provider retention and recruitment. The Contractor shall provide DCH with the Provider exit survey template initially and when updated thereafter. The Contractor shall provide DCH with results of the Provider exit surveys upon request.	Yes
4.8.3.1 The Contractor shall maintain an online Provider Directory and Network Listing.	Yes
4.8.3.2 The Contractor shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted Providers which shall include the use of access and availability audits described in Section 4.8.19.6. Failure to conduct quarterly validation and provide a clean file after determining errors through validation may result in liquidated damages up to $5,000 per day against the Contractor.	Yes
4.8.3.3 The Contractor shall ensure that all Provider network data files are tested and validated for accuracy prior to Contractor deliverable submissions, which shall include the use of access and availability audits described in Section 4.8.19.6. The Contractor shall scrub data to identify inconsistencies such as duplicate addresses; mismatched cities, counties, and regions; and incorrectly assigned specialties. The Contractor shall be responsible for submission of attestations for each network report. All reports are to be submitted in the established DCH format with all required data elements. Failure to submit all attestations and complete reports in the established DCH format with all required data elements may result in liquidated damages up to $5,000 per day against the Contractor.	Yes
4.8.3.4 The Contractor shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, and must be documented in record. The Contractor will emphasize to Providers the need for a unique GA Medicaid number for each practice location unless DCH changes this requirement at a future date.	Yes
4.8.4.1 The Contractor shall allow for PCPs to include not only traditional provider types that have historically served as PCPs but also alternative provider types such as specialists and patient-centered medical homes (PCMHs) with documented physician oversight and meaningful physician engagement.	Yes

Quality Improvement

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.12.1.2 The Contractor shall seek input from, and work with, Members, Providers, community resources, and agencies to actively improve the Quality of care provided to Members.	Yes
4.12.1.3.1 The Contractor shall obtain National Committee for Quality Assurance (NCQA) Interim Status by the Operational Start Date. Contractors shall apply for NCQA accreditation, or at other times as required by DCH as follows:	Yes
4.12.1.3.1.1 July 1, 2016: Apply for NCQA Interim Status	Yes
4.12.1.3.1.2 July 1, 2017: Apply for provisional status (first survey)	Yes
4.12.1.3.1.3 December 31, 2017: Notify NCQA of intent to submit data	Yes
4.12.1.3.1.4 June 15, 2018: Submit CY 2017 data	Yes
4.12.1.3.2 The Contractor shall achieve NCQA Commendable or Excellent accreditation status within three (3) years after the Operational Start Date. Contractors that lose NCQA Commendable or Excellent status must regain the status within one (1) year.	Yes
4.12.1.4.1 The Contractor shall establish a multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities. This committee shall meet at least quarterly, but more often if warranted. The formal organizational structure must include at a minimum, the following:	Yes
4.12.1.4.1.1 A designated health care practitioner, qualified by training and experience, to serve as the QM Director;	Yes
4.12.1.4.1.2 A committee which includes representatives from the provider groups as well as clinical and nonclinical areas of the organization;	Yes
4.12.1.4.1.3 A senior executive who is responsible for program implementation;	Yes
4.12.1.4.1.4 Substantial involvement in QM activities by the Contractor's Medical Director; and	Yes
4.12.1.4.1.5 Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.	Yes
4.12.1.4.2 The Quality Management Committee must:	Yes
4.12.1.4.2.1 Maintain Records that document the committee's activities, findings, recommendations, actions, and results; and	Yes
4.12.1.4.2.2 Obtain DCH's approval of membership of the Quality Oversight Committee.	Yes
4.12.2.1 The Contractor shall support and comply with the DCH Quality Strategic Plan. The DCH Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to GF and Members as defined in Title 42 of the Code of Federal Regulations (42 CFR) 431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 CFR 438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 CFR Part 164 (HIPAA Privacy Requirements).	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.12.2.2 The DCH Quality Strategic Plan promotes improvement in the Quality of care provided to enrolled Members through established processes. DCH staff within the Performance, Quality and Outcomes Unit are responsible for oversight of the Contractor's Quality program including:	Yes
4.12.2.2.1 Monitoring and evaluating the Contractor's service delivery system and Provider network, as well as its own processes for quality management and performance improvement;	Yes
4.12.2.2.2 Implementing action plans and activities to correct deficiencies and/or increase the Quality of care provided to enrolled Members;	Yes
4.12.2.2.3 Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews, etc.;	Yes
4.12.2.2.4 Monitoring compliance with Federal, State and DCH requirements;	Yes
4.12.2.2.5 Ensuring the Contractor's coordination with State registries;	Yes
4.12.2.2.6 Ensuring Contractor executive and management staff participation in the Quality management and performance improvement processes;	Yes
4.12.2.2.7 Ensuring that the development and implementation of Quality management and performance improvement activities includes Provider participation and information provided by Members, their families and guardians; and	Yes
4.12.2.2.8 Identifying the Contractor's best practices for performance and Quality improvement.	Yes
4.12.3.1 The Contractor shall comply with the GF 360º DCH Quality Strategic Plan requirements to improve the health outcomes for all Members. Improved health outcomes will be documented using established performance measures. DCH uses the CMS issued CHIPRA Core Set and the Adult Core Set of Quality Measures technical specifications along with the Healthcare Effectiveness Data and Information Set (HEDIS®) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for the quality and health improvement performance measures. DCH will monitor Performance Measures and incent Contractor improvement through the Value-based Purchasing program.	Yes
4.12.3.2 Several of the Adult and Child Core Set measures along with certain other HEDIS® measures utilize hybrid methodology, that is, they require a medical record review in addition to the administrative data requirements for measurement reporting. The number of required record reviews is determined by the specifications for each hybrid measure.	Yes
4.12.3.3 DCH established Performance Measure Targets for each measure. It is important that the Contractor continually improve health outcomes from year to year. The performance measure targets, as amended from time to time, for each performance measure can be accessed at http://dch.georgia.gov/medicaid-quality-reporting. Performance targets are based on national Medicaid Managed Care HEDIS® percentiles as reported by NCQA or other benchmarks as established by DCH.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.12.3.4 DCH may also require a Corrective Action (CA) or Preventive Action (PA) form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CA or PA form must be received by DCH within thirty (30) Calendar Days of receipt of notification of lack of achievement of performance targets. The CA or PA response must be approved by DCH prior to implementation. DCH may conduct follow up on-site reviews to verify compliance with a CA or PA response. DCH may assess Liquidated Damages on Contractors who do not meet the performance measure targets for any one performance measure.	Yes
4.12.3.5 The performance measures apply to the Member populations as specified by the measures' technical specifications. Contractor performance is evaluated annually on the reported rate for each measure. Performance Measures, benchmarks, and/or specifications may change annually to comply with industry standards and updates.	Yes
4.12.3.6 The Contractor must provide for an independent Validation of each performance measure rate and submit the validated results to DCH no later than June 30 of each year.	Yes
4.12.5.1 The Contractor shall implement Member and Provider incentives to increase Member and Provider participation in reaching program goals.	Yes
4.12.6.1 The Contractor shall have in place an ongoing QAPI program consistent with 42 CFR 438.240. The program must be established utilizing strategic planning principles with defined goals, objectives, strategies and measures of effectiveness for the strategies implemented to achieve the defined goals.	Yes
4.12.6.3 The Contractor shall conduct PCP and other Provider profiling activities as part of its QAPI Program. Provider profiling must include multi-dimensional assessments of PCP's or Provider's performance using clinical, administrative and Member satisfaction indicators of care that are accurate, measurable and relevant to Members.	Yes
4.12.6.4 The Contractor's QAPI Program Plan must be submitted to DCH for initial review and approval and as updated thereafter.	Yes
4.12.6.7 Annually, the Contractor shall submit to DCH a comprehensive QAPI Report, utilizing the report template that integrates all aspects of the QAPI Plan and tells the story of the effectiveness of the Contractor's QAPI Plan in meeting defined goals and objectives and achieving improved health outcomes for the Contractor's Members. DCH may require interim reports more frequently than annually to demonstrate progress.	Yes
4.12.7.1 As part of its QAPI program, the Contractor shall conduct clinical and non-clinical Performance Improvement Projects in accordance with DCH and federal protocols.	Yes
4.12.8.1 The Contractor shall adopt a minimum of three (3) evidence-based clinical practice guidelines.	Yes

Required Assessments and Screenings

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.7.7.3.1 A critical component of the success of the Contractor depends upon the Contractor's ability to conduct and report required assessments and screenings upon Member enrollment. These tools are used to identify immediate needs of Members transitioning into and out of GF 360º. Required assessments and screening vary by population type and include:	Yes
4.7.7.3.1.1.1 The CCFA (Comprehensive Child & Family Assessment) is used by DFCS to assist in developing case plans, making placement decisions, expediting permanency and planning for effective service intervention. The Contractor shall be responsible for ensuring that the Medical and Trauma Assessments required for the FC Members as part of the CCFA are conducted and reported in a timely manner as set forth herein. Each instance of failure to meet a timeframe specified in this Section shall constitute a Category 4 event as set forth in Section 25.5.	Yes
4.7.7.3.1.1.2 Includes all EPSDT periodicity schedule requirements relevant to the Member's age. The Contractor shall ensure Providers conducting the Medical Assessment provide outcomes of the Assessment to the Contractor within twenty (20) Calendar Days of the Contractor's receipt of the eligibility file from DCH or electronic notification from DFCS or DCH. The Contractor must provide outcomes of the Medical Assessments to the DFCS-contracted CCFA Provider within twenty (20) Calendar Days of the Contractor's receipt of the eligibility file from DCH or electronic notification from DFCS or DCH.	Yes
4.7.7.3.1.2.1 The Trauma Assessment Screening, at a minimum, shall include:	Yes
4.7.7.3.1.2.1.1 A trauma history with information about any trauma that the child may have experienced or been exposed to as well as how they have coped with that trauma in the past and present.	Yes
4.7.7.3.1.2.1.2 Completion of the age appropriate assessment tool.	Yes
4.7.7.3.1.2.1.3 A summary of assessment results and recommendations for treatment (if needed).	Yes
4.7.7.3.1.2.2 The Contractor shall contract with CCFA Providers for the provision of CCFA Trauma Assessment Screenings for the following Members:	Yes
4.7.7.3.1.2.2.1 Members Newly Entering or Re-entering Foster Care	Yes
4.7.7.3.1.2.2.1.1 The Contractor shall ensure that the CMO-contracted CCFA Provider has initiated contact with or visit(s) with the Member newly entering or re-entering Foster Care as a FC Member and begins the Trauma Assessment within ten (10) Calendar Days of the Contractor's receipt of written notification from DFCS of the FC Member's seventy-two (72)-hour hearing. The Contractor must coordinate all necessary visits with the CMO contracted CCFA Provider to ensure that the final Trauma Assessment is completed within the timeframes referenced in this Contract.	Yes
4.7.7.3.1.2.2.1.2 The CMO-contracted CCFA Provider must prepare a written Trauma Assessment report and submit such report to the Contractor. The Contractor must then submit the written Trauma Assessment report to the DFCS contracted CCFA provider preparing the final CCFA report within twenty	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
(20) Calendar Days of the Contractor's receipt of written notification from DFCS of the FC Member's seventy-two (72)-hour hearing. If the CMO contracted CCFA Provider is unable to meet the timeframe for the written Trauma Assessment report, the CMO-contracted CCFA Provider may verbally report the Trauma Assessment findings and recommended treatment during the FC Member's multidisciplinary team meeting. In the case of a verbal report, the Contractor shall be responsible for assuring the CMO-contracted CCFA Provider submits the final written Trauma Assessment report to the DFCS contracted CCFA provider preparing the final CCFA report within thirty-five (35) Calendar Days of the Contractor's receipt of written notification from DFCS of the FC Member's seventy-two (72)-hour hearing.	
4.7.7.3.1.2.2.2 Trauma Assessments for AA Members and Enrolled FC Members	Yes
4.7.7.3.1.2.2.2.1 Trauma Assessments may be required for AA Members in the event of abuse or neglect as reported by a Provider, Adoptive Parent or others. Trauma Assessments may also be required for a Member who has been an FC Member for a period of twelve (12) or more months and whose completed CCFA is more than twelve (12) months old. Under these two (2) circumstances, the Contractor shall:	Yes
4.7.7.3.1.2.2.2.1.1 Ensure that the CMO-contracted CCFA Provider has initiated contact with or visit(s) with the AA or FC Member and begins the Trauma Assessment within ten (10) Calendar Days of the Contractor's receipt of written notification from DFCS. The Contractor must coordinate all necessary visits with the CMO contracted CCFA Provider to ensure that the final Trauma Assessment is completed within the timeframes referenced in the RFP and this Contract.	Yes
4.7.7.3.1.2.2.2.1.2 The CMO-contracted CCFA Provider must prepare a written Trauma Assessment report and submit such report to the DFCS-contracted CCFA provider preparing the final CCFA report within twenty (20) Calendar Days of the Contractor's receipt of written notification from DFCS.	Yes
4.7.7.3.1.2.2.2.1.3 If the CMO-contracted CCFA Provider is unable to meet the timeframe for the written Trauma Assessment report, the CMO-contracted CCFA Provider may verbally report the Trauma Assessment findings and recommended treatment. In the case of a verbal report, the Contractor shall be responsible for assuring the CMO-contracted CCFA Provider submits the final written Trauma Assessment report to the DFCS-contracted CCFA provider preparing the final CCFA report within thirty-five (35) Calendar Days of the Contractor's receipt of written notification from DFCS.	Yes
4.7.7.3.1.2.2 The Contractor shall coordinate for and ensure that FC or AA Members follow up on and receive any care specified within the Trauma and Medical Assessments in accordance with the following timeliness requirements. The Contractor shall:	Yes
4.7.7.3.1.2.2.1 Provide follow up for dental treatment within thirty (30) Calendar Days of the EPSDT dental visit if the dental screening yields any concerns or the need for dental treatment.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s) *Yes or No*
4.7.7.3.1.2.2.2 Obtain an audiological assessment and treatment or prescribed corrective devices initiated within thirty (30) Calendar Days of the screening, based on the results of the hearing screening.	Yes
4.7.7.3.1.2.2.3 Provide a developmental assessment if the developmental screening completed as part of the EPSDT visit yields any developmental delays or concerns. The EPSDT provider is responsible for making a referral for the assessment, and the Contractor is responsible for ensuring the child has the assessment within thirty (30) Calendar Days of the screening.	Yes
4.7.7.3.1.2.2.4 Ensure that Providers refer FC Members ages three (3) years and under who are exposed to Substantiated Maltreatment to the Children 1st program for a developmental screening as required by the Child Abuse Prevention and Treatment Act (CAPTA).	Yes
4.7.7.3.1.3.1 The Contractor shall be responsible for assuring the Medical Assessments for DJJ Members are completed within ten (10) Calendar Days of the Contractor's receipt of the eligibility file from DCH or electronic notification from DFCS or DCH whichever comes first for a Member newly entering or re-entering as a DJJ Member.	Yes
4.7.7.3.1.3.2 Providers conducting the assessment must provide outcomes to the Contractor and the Contractor shall send the outcome of the Medical Assessment to the DJJ Member's Residential Placement Provider within fifteen (15) Calendar Days of the Contractor's receipt of the eligibility file from DCH or electronic notification from DJJ, whichever comes first, for a Member newly entering or re-entering as a DJJ Member.	Yes
4.7.7.3.1.3.3 The medical components of the Medical Assessment for the DJJ Member shall include an initial medical evaluation that includes all components of the EPSDT periodicity schedule relevant for the age of the DJJ Member.	Yes
4.7.7.3.1.4.1 The Contractor shall provide a Health Risk Screening within thirty (30) days of receipt of the eligibility file from DCH. The Health Risk Screening is used to develop a comprehensive understanding of the Members' health status and will be used by the Contractor to develop the Health Care Service Plan and used by the Care Coordination Team to determine the Member's Care Coordination needs.	Yes
4.7.7.3.1.4.2 The Health Risk Screening is independent of the assessments conducted for the CCFA; however, the Contractor may utilize the information from the CCFA assessments it coordinates to further inform the comprehensive understanding of the Member's health.	Yes
4.7.7.3.1.4.3 The Contractor must assess the need to complete a new Health Risk Screening each time a Member moves to a new placement or based on a change in the Member's medical or behavioral health as identified by Providers.	Yes
4.7.7.3.1.4.4 The Contractor shall submit policies and procedures for conducting the Health Risk Screening and the tools that will be used to conduct the screenings to DCH for review and approval within one hundred twenty (120) Calendar Days of the Operational Start Date.	Yes

Utilization Management

Contract Language	AGP Policy Is Consistent with Contract Requirement(s)? *Yes or No*
4.11.1.1 The Contractor shall implement innovative and effective Utilization Management processes to ensure a high quality, clinically appropriate yet highly efficient and cost-effective delivery system. The Contractor shall continually evaluate the cost and Quality of medical services provided by Providers and identify the potential under and over-utilization of clinical services. The Contractor must apply objective and evidence-based criteria that take the individual Member's circumstances and the local delivery system into account when determining the medical appropriateness of Health Care services	Yes
4.11.1.2 The Contractor shall enable Pre-Certification of service requests when required and direct Providers in making appropriate clinical decisions for the Member in the right setting and at the right time. As part of its regular processes for conducting Utilization Review, the Contractor must evaluate all review requests for Medical Necessity and make recommendations that are more appropriate and more cost-effective. The Contractor should leverage findings from current federal efforts around comparative effectiveness research to support its evaluation of requests.	Yes
The Contractor shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion. Specifically, the Contractor shall have written Utilization Management Policies and Procedures that:	Yes
4.11.1.3.1 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.	Yes
4.11.1.3.2 Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.	Yes
4.11.1.3.3 Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.	Yes
4.11.1.3.4 Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition as stated in Sections 1.4 and 4.5.4.	Yes
4.11.1.3.5 Provide for the appeal by Members, or their representative, of authorization decisions, and guarantee no retaliation will be taken by the Contractor against the Member for exercising that right.	Yes
4.11.1.4 Contractor must consider the role of non-medical factors (ex. Placement changes, involvement with the juvenile justice system, etc.) that may drive inappropriate Utilization of medical resources when developing Utilization Management Policies and Procedures.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s)? *Yes or No*
4.11.1.5 The Contractor shall submit the Utilization Management Policies and Procedures to DCH for review and prior approval annually and as changed. Nothing in this Section shall prohibit or impede the Contractor from applying a person-centric clinical decision that may vary from the written Utilization Management Policies and Procedures in so far as that decision is accompanied by the clinical rationale for such a decision.	Yes
4.11.1.6 Network Providers may participate in Utilization Review activities to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures shall define when such a conflict may exist and shall describe the remedy.	Yes
4.11.1.6.1.1 The Contractor shall establish a Utilization Management Committee. The Utilization Management committee is accountable to the Medical Director and governing body of the Contractor. The Utilization Management Committee shall meet no less frequently than a quarterly basis and maintain records of activities, findings, recommendations, and actions. Reports of these activities shall be made available to DCH upon request.	Yes
4.11.2.1 The Contractor shall not require Prior Authorization or Pre-Certification for Emergency Services, Post-Stabilization Services, or Urgent Care services, as described in Section 4.6.1, 4.6.2, and 4.6.3, Special Coverage Provisions.	Yes
4.11.2.2 The Contractor shall require Prior Authorization and/or Pre-Certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.	Yes
4.11.2.3 The Contractor may require Prior Authorization and/or Pre-Certification for all non-emergent, Out-of-Network services.	Yes
4.11.2.4 Prior Authorization and Pre-Certification shall be conducted by a currently Georgia licensed, registered or certified Health Care Professional who is appropriately trained in the principles, procedures and standards of Utilization Review.	Yes
4.11.2.5 The Contractor and its network Providers (except: Pharmacy Providers) shall use DCH's central Prior Authorization Portal for communicating Prior Authorization and Pre-Certification requests and their disposition. The Contractor shall establish an interface with the Prior Authorization Portal that allows the Contractor to receive and submit required data. The Prior Authorization and Pre-Certification process shall be one hundred percent (100%) paperless. The Contractor shall conduct outreach to and educate network Providers about use of the Portal and submission of all required documentation through the Portal.	Yes
4.11.2.6 The Contractor will retain authority for reviewing requests and making Prior Authorization and Pre-Certification determinations. The Contractor shall implement policies and procedures that incorporate how the Contractor will conduct the following activities:	Yes
4.11.2.6.1 Accept Prior Authorization and Pre-Certification requests that Providers submit on a standardized form developed by DCH through the Prior Authorization Portal.	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s)? *Yes or No*
4.11.2.6.2 Communicate requests for additional information from the Provider through the Prior Authorization Portal. The Contractor may directly contact the Provider with questions, but the Contractor shall communicate the same information through the Prior Authorization Portal.	Yes
4.11.2.6.3 Review requests when a Member has an outstanding Prior Authorization and transitions enrollment to the Contractor. The Contractor may not require the requesting Provider to re-submit the Prior Authorization request. The Contractor may make its own determination regarding approval of the request.	Yes
4.11.2.7 The Contractor shall notify the Provider of Prior Authorization determinations via the Prior Authorization Portal in accordance with the following timeframes.	Yes
4.11.2.7.1 Standard Service Authorizations. Prior Authorization decisions for non-urgent services shall be made within three (3) Business Days, or other established timeframe, of the request (generally submitted one week prior to the service or procedure). An extension may be granted for an additional fourteen (14) Calendar Days if the Member or the Provider requests an extension, or if the Contractor justifies to DCH a need for additional information and the extension is in the Member's best interest.	Yes
4.11.2.7.2 Expedited Service Authorizations. For cases in which a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Contractor must make an expedited authorization decision with twenty-four (24) clock hours and provide notice as expeditiously as the Member's health condition requires and no later than three (3) Business Days after receipt of the request for service. The Contractor may extend the twenty-four (24) clock hour period for up to five (5) Business Days if the Contractor justifies to DCH a need for additional information and how the extension is in the Member's best interest.	Yes
4.11.2.7.3 Authorization for Services that have been Delivered. Determinations for authorization involving health care services that have been delivered shall be made within thirty (30) Calendar Days of receipt of the necessary information.	Yes
4.11.2.8 The Contractor's policies and procedures for authorization shall include consulting with the requesting Provider when appropriate.	Yes
4.11.2.9 The Contractor may require that the prescriber's office request Prior Authorization as a condition of coverage or payment for a prescription drug provided that a decision whether to approve or deny the prescription is made within twenty-four (24) clock hours of the Prior Authorization request. If a Member's prescription for a medication is not filled when a prescription is presented to the pharmacist due to a Prior Authorization requirement, the Contractor must allow the pharmacist to dispense a seventy two (72) hour emergency supply of the prescribed. The Contractor must reimburse the pharmacy for the temporary supply of medication and contracted dispensing fee. The Contractor's Prior Authorization processes for Behavioral Health Services shall recognize the intensive and/or ongoing need for these services often present among the Members, and should not be unnecessarily	Yes

Contract Language	AGP Policy Is Consistent with Contract Requirement(s)? *Yes or No*
burdensome to Providers or the Members. For example, Medical Necessity reviews for Member stays in a Psychiatric Residential Treatment Facility (PRTF) must account for the high level needs of the Members and must not be unnecessarily burdensome for Providers or the CMO. DCH recommends that the Contractor does not conduct Medical Necessity reviews for Members in a PRTF more frequently than every seven (7) Calendar Days.	
4.11.2.10 Prior Authorization will not be required for the first twelve (12) individual or group outpatient psychotherapy sessions provided by a contracted Behavioral Health provider, per twelve (12)-month rolling period. Such sessions may include the initial evaluation. Additional visits will be reviewed and approved based on a Medical Necessity review conducted by the Contractor.	Yes
4.11.3.1 The Contractor may require that Members obtain a Referral from their PCP prior to accessing non-emergency specialized services.	Yes
4.11.3.2 In the Utilization Management Policies and Procedures discussed in Section 4.11.1, the Contractor shall address:	Yes
4.11.3.2.1 When a Referral from the Member's PCP is required;	Yes
4.11.3.2.2 How a Member obtains a Referral to an In-Network Provider or an Out-of-Network Provider when there is no Provider within the Contractor's network that has the appropriate training or expertise to meet the particular health needs of the Member;	Yes
4.11.3.2.3 How a Member with a Condition which requires on-going care from a specialist may request a standing Referral; and	Yes
4.11.3.2.4 How a Member with a life-threatening Condition or disease, which requires specialized medical care over a prolonged period of time, may request and obtain access to a specialty care center.	Yes
4.11.3.3 The Contractor shall prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a member of the Provider's family has a Financial Relationship.	Yes
4.11.3.4 The Contractor shall develop electronic, web-based Referral processes and systems. In the event a Referral is made via the telephone, the Contractor shall ensure that the Contractor, the Provider and DCH maintain Referral data, including the final decision, in a data file that can be accessed electronically.	Yes
4.11.3.5 In conjunction with the other Utilization Management policies, the Contractor shall submit the Referral processes to DCH for review and approval.	Yes