Our Quality Improvement Program

When it comes to quality, we’re guided by:

- Results-based studies conducted by our Quality Improvement program team
- Sound advice from internal and external experts
- National standards set by NCQA
- Current research that informs the criteria we use
- First-hand experience of case managers who know our members’ needs

Our comprehensive program:

- Adheres to HEDIS standards and measures our progress to meet annual goals
- Objectively monitors and evaluates the care and services our members receive
- Plans studies across the continuum of care and service to ensure ongoing, proactive evaluation and refinement of our program
- Reflects the demographic and epidemiological needs of each population served
- Encourages both members and providers to recommend improvements
- Identifies ways we can promote and improve patient safety

We know you’ve heard of HEDIS, established by the National Committee for Quality Assurance (NCQA). We send you report cards, letters and reminders about members overdue for services related to HEDIS measures — you might even be eligible for incentive payments when helping members get these important services.

But it’s not just about the scores. It’s about the woman whose Pap smear led to early detection and treatment of her cervical cancer. Or the toddler who didn’t get whooping cough during last year’s outbreak because he got his shot on time. Or the grandfather who kept up with cholesterol screenings and avoided another heart attack.

We thank you for giving our members the highest quality care possible. Working together to meet these benchmarks, we have the best chance of improving our members’ health outcomes and, ultimately, their quality of life.

We welcome your suggestions! To let us know how we might improve our program, contact your Provider Relations representative.

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More Than a Score: Working Together to Achieve Better Health Outcomes While Meeting HEDIS Measures

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Our Benchmarks for Clinical Performance and Service Satisfaction

HEDIS — Healthcare Effectiveness Data and Information Set (HEDIS) — a program developed by the NCQA to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 80 measures across five domains of care.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) — a survey evaluating member satisfaction with care and services received over the past six months by questioning a random sample of plan members on their doctors and the health plan.

Provider Satisfaction Survey — an annual survey to find out what you, our providers, think we’re doing well and what we can do better in several capacities, including communication and technology, claims processing, and customer service.

HEDIS, CAHPS and the Provider Satisfaction Survey results help us identify areas of strength and areas where we need to focus our improvement efforts. We use the results to:

- Measure our performance against our goals
- Determine the effectiveness of actions we implemented to improve our results

HEDIS is a registered trademark of the NCQA. CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
Help Us Meet the Measure:  
HEDIS Guidelines for Children and Adolescents

Helping our members achieve and maintain good health is our mission. When we achieve that goal through preventive health practices and screenings, we also meet or exceed HEDIS measures.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Overweight and obese youth risk developing serious health problems as adults, like heart disease, osteoarthritis, strokes, type 2 diabetes and certain types of cancer. Overweight children are more likely to be overweight as adults. They may also suffer from bullying and social isolation, which can lead to poor self-esteem, grades and social skills.

The effects of obesity can reach into almost every aspect of a person’s life. You are in a unique position to help children develop healthy habits, so we encourage you to remember to do the following during an exam:

- Measure height and weight
- Perform a BMI screening and education
- Complete a nutritional review
- Document activities and exercise patterns to provide nutritional counseling or referrals as needed

Children’s Immunizations and Lead Screening

There are two HEDIS measures for immunizations: Childhood Immunization Status (CIS) — an assessment of children who had their 2nd birthday in 2013 — and Immunizations for Adolescents (IMA) — an assessment of children who had their 13th birthday in 2013. Both measures assess children who received the vaccinations for their ages recommended by the Centers for Disease Control and Prevention (CDC).

Lead Screening in Children (LSC) assesses whether children who were age 2 during the 2013 measurement year had capillary or venous blood tests for lead poisoning on or before their 2nd birthdays.

You can help us achieve these HEDIS measures by encouraging parents to bring their children in for regular checkups and immunizations.
Advance Directives —
Preparing Members and Families for Difficult Decision-Making

It’s critical to discuss the importance of advance directives — either living wills or durable powers of attorney — with members in your care. Taking this important step ensures their wishes are followed in the event of debilitating injuries or illnesses.

Remember...

- All members over the age of 18 have the right to an advance directive.
- You may not condition the provision of care or otherwise discriminate against a member based on whether or not he or she has executed an advance directive.
- Maintain information on the member’s advance directive in the medical record — we audit for this information when conducting medical record reviews.
- Check our provider website for links to templates for living wills and durable powers of attorney — some states require use of a state-produced form.

Managed Long-Term Services and Supports Coming Soon

Managed Long-Term Services and Supports (MLTSS), the state’s Medicaid program for the physically disabled and elderly, provides services to help people remain living independently in their communities or, if their needs are too great, in nursing facilities. The program will also have an element of care coordination. We were awarded the opportunity to begin serving members who live at home in January 2014 and members who live in nursing homes in July 2014. We’ll announce more on this program as news becomes available.

More Than Just a Sore Throat

Pharyngitis is the leading cause of pediatric ambulatory care visits.

There are no disease-specific symptoms that distinguish Group A beta-hemolytic streptococcus from other bacterial or viral upper respiratory infections. A rapid strep test or culture should be performed for children diagnosed with pharyngitis before beginning antibiotic therapy, especially those age 2 and older as untreated Group A strep pharyngitis may cause rheumatic fever.

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Access to Case Management

Did you know, in addition to our disease management programs, we offer complex case management for our high-risk members? Using claims and utilization data, we identify members at risk for or susceptible to certain diseases. Then we:

- Use evidence-based guidelines to coordinate care with the member, his or her family, physicians, and other health care providers
- Work with everyone involved in the member’s care to help implement a case management plan based on the member’s needs
- Provide education and support to our members and their families to help our members improve their health and quality of life

If you have a high-risk member you would like to refer to this program, call our Provider Services team for help.

Clinical Practice and Preventive Health Guidelines

On our provider self-service site, we offer clinical care and preventive health guidelines based on current research and national standards known to be effective in improving health outcomes. Effectiveness of guidelines is determined by scientific evidence, professional standards or expert opinion.

Need a paper copy of a guideline? Call our Provider Services team.

Utilization Management Criteria

If one of our medical directors denies your service request, we’ll send you and the member a notice of proposed action letter, including the reason for denial, the criteria/guidelines used for the decision and an explanation of your appeal process and rights. To speak with a medical director about the service request denial, call the number on your letter or our Provider Services team for help. To request a copy of the specific criteria/guidelines used for the decision, call our Provider Services team and ask to speak to a Clinical team member.

Our Utilization Management Team

Our team members, including the clinical professionals who coordinate our members’ care, are governed by the following statements:

- Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage.
- We do not specifically reward practitioners or other individuals for issuing denial of coverage or care.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

We’re available 24 hours a day, 7 days a week to accept precertification requests.

Submit requests by:

- Calling our Provider Services team
- Faxing to 1-800-964-3627
- Logging in to our provider self-service website
Even with the deadline over a year away, time is still ticking toward compliance with ICD-10. CMS recommends you test ICD-10 compliance with business partners, colleagues and staff now. Whether you’re on track or have a way to go, we’re here to help. We’ve posted CMS resources like FAQs and implementation guides on our provider website. Or go straight to the source at www.cms.gov or follow @CMSgov on Twitter.

Thank you for participating in our network, providing quality health care to our members and cooperating in our annual review process.
With a **Continuously Improved** Online Experience

We make your experience with our provider self-service site even smoother with recently enhanced precertification request features and new claims appeal options. Not yet registered to use our site? Click Login Help, then New User Registration from the top menu bar to get started.

**To see the status of your precertification request, detailed reasons for denials or partial denials and more:**
- Log in
- On the Tools menu, select Precertification, then Status
- Complete the required fields, then click Check Status

**To submit claims appeals and upload documents to support your appeal:**
- Log in
- Select Claims, then Status on the Tools menu
- Enter the start date and desired end date of the date of service
- Select the claim you want to view
- Click Appeal Claim
- Complete the Summary of Appeal and Claim Appeal Contact Information forms

To receive a response to your appeal request sooner, choose email delivery.

**Use our online medication precertification tool to:**
- Request general pharmacy* and onsite infusion or administration medical injectables
- Check medication precertification status
- Appeal denials and check their status
- Upload supporting documents

Online Medication Precertification will be available for all providers in July and may already be in use for your state.

*Not available in Tennessee and Texas

For a quick lesson on our new site tools and features, click Tutorials in our online Provider Resources & Documents library on the home page.

**HELPING YOU...**

Beginning early in the third quarter of this year, you’ll get faster, better information through enhancements like:

- **Ability to check precertification requirements** — you can always check these online, but if you don’t have access to the Internet, use this service by phone
- **Enhanced claims read-back** — now, you’ll also hear about rejected claims in your status list
- **Easier data entry** — an option to select more time, when you need it, to research records info you must enter; this prevents the system from ending your call or timing out
- **Enhanced recognition for better call routing** — routes you to representatives and options that better meet your needs based on the authentication you enter, like NPI or TIN
- **Prerecorded messages** — give you timely information about what’s going on with Amerigroup in your state, even late-breaking news

**Make Sense of the Medicaid Rate Increase for PCPs**

As part of the Patient Protection and Affordable Care Act (Affordable Care Act), Section 1202, all states must increase reimbursements for eligible primary care practitioners to 100 percent of Medicare rates for certain Evaluation and Management and vaccine administration codes. The goal of this initiative is to encourage greater provider participation in Medicaid plans heading into an era of health reform.

State Medicaid agencies and Medicaid managed care organizations will pay eligible providers increased rates for eligible services rendered between January 1, 2013, and December 31, 2014.

Check our provider self-service site for news on the progress in your state. Each state determines its own procedures for attestation of eligibility and payments of the rate increase (pending approval of state plan amendments filed with CMS). Our site gives you updated information as we hear it and links to previous communications, required forms, and state announcements or websites for further info about this ongoing initiative.

Looking for a reliable source of information about health reform in general? Visit **hcr.amerigroup.com** to stay up-to-date.

**Get Faster, Better Information When You Call**

Our Customer Experience team recently conducted focus groups with members and providers to make our Interactive Voice Response (IVR) system better.
We’ve made it easier than ever to access our referral directories. Download the Amerigroup Mobile app to your smartphone or tablet, and you’re good to go — get it free on iTunes or Android.

When you speak to patients about the importance of **cervical cancer screening**, they are more likely to get the exams.

Screening is recommended for women ages 21 to 64. If a woman has a negative Pap test and no history of abnormal Pap tests, she may be screened every three years.

We are concerned about the **reproductive health** of our members.

We encourage you to perform annual chlamydia screenings for women ages 16–24 who are sexually active. Amerigroup providers had a 55-percent HEDIS chlamydia screening rate for 2012, while the national average was 58 percent.

Did you know one of the most common culprits behind denied claims is an incomplete **Sterilization Consent Form**?

Be sure to correctly and completely fill in this form before filing to avoid claims payment delays and denials.

Don’t forget: you must transfer a member’s medical records to him or her or other providers at no charge **within 10 days** of the request.
More Opportunities for Quality Care

Increase Medication Compliance With 90-Day Prescriptions

Did you know converting your patients’ 30-day supplies of diabetic medications like ACEI/ARBS/DRI or statins to 90-day prescriptions can help them maintain their regimens and stay on their medications?

Start prescribing 90-day medications where appropriate!

**It’s convenient:** Patients can have three-month supplies of medications mailed right to their homes or pick up prescriptions at local retail pharmacies.

**It saves time:** Patients only have to refill their prescriptions four times per year instead of 12.

**It removes barriers:** 90-day refills help patients who lack transportation, have busy schedules or may just be forgetful when it comes to refilling medications.

Our Pharmacy team will reach out to you by mail or phone to let you know which patients you can help through 90-day prescriptions. If you have questions or need more information about how 90-day prescriptions increase medication therapy compliance, call the Pharmacy department in our Medicare Dedicated Service Unit at 1-866-805-4589.

Get Help From Our Quality Team

From member outreach and education materials to tools and training for you and your staff, we offer the resources and support you need to keep members healthy.

**What can a quality nurse do for you?**

- Give you copies of the Missed Opportunity Report — a list of members who haven’t completed certain preventive care exams
- Provide education materials you can share with members
- Work with you to get members into your office
- Provide training for completing Health Risk Assessments and using the Missed Opportunity Report
- Perform medical record reviews

This summer, our quality nurses will contact you to discuss even more ways they can help. To talk to a quality nurse or schedule a visit, call 1-866-805-4589.

**What can an outreach associate do for you?**

- Use the Missed Opportunity Report to contact members who haven’t received preventive care exams on your behalf
- Set up three-way calls with you and a member to encourage office visits
- Conduct home visits for hard-to-reach members to arrange appointments, transportation and other services
August 1 Changes to Precertification Guidelines

Be sure to check our online precertification tool before you order services for our members. We already sent you notice, but as a reminder, many of our precertification guidelines are changing on August 1, 2013.

In December 2012, Amerigroup Corporation and its subsidiary health plans were purchased by WellPoint, Inc. Because of this change in ownership, we are aligning our medical policies, utilization management guidelines and precertification rules with UniCare — a subsidiary of WellPoint. In all cases, state Medicaid contracts and CMS guidelines supersede UniCare guidelines — this is reflected in our precertification rules.

Visit our provider website Quick Tools to find out more detail and link to the specific policies.

Clinic Days are a great way to get members caught up on the care they’re missing.

These new, in-office events help you get members the important preventive care they need quickly.

We’ll help you set up a one-stop shop by scheduling blocks of time for Amerigroup-only appointments and arranging for laboratory, vision care or other needed services to also be on hand.

Contact your quality nurse or call 1-866-805-4589 to plan a Clinic Day for your office.

Not receiving the Missed Opportunity Report?

Call Quality Management at 1-866-805-4589 to get it.
Establishing meaningful policies and procedures is essential for ensuring quality health care.

The Amerivantage Quality Management Committee (AQMC) is the cornerstone of quality for our Amerivantage programs and reviews all medical quality-related activities that impact our nearly 50,000 Medicare Advantage and dual-eligible members.

With expertise from providers like you and staff from various Amerigroup departments like Health Care Management Services, our Medicare Dedicated Service Unit, and the Medicare Appeals and Grievances Team, the AQMC works to improve the member and provider experience, increase access to care and improve care.

What the AQMC has accomplished year-to-date:
- Explored new ways to increase medication adherence rates for members with diabetes, hypertension and elevated cholesterol levels
- Examined the performance of our call centers and ways to improve customer service
- Considered incentives to encourage providers to perform HRAs each year for their Amerivantage patients

Meet Our AQMC Chair

Dr. David Ackman, M.D., MPH, is a national medical director and chair of our AQMC. This role is the capstone of a long career designing and implementing health care strategies to increase quality. From his home base in New York, Dr. Ackman has forged a multi-faceted career in public health and specialized medicine. He began working as an epidemic intelligence service officer for the Centers for Disease Control and Prevention, and then served as the director of disease control for the state of New York. He later became the health commissioner for Nassau County and the medical director of ambulatory care for New York’s Presbyterian Hospital. Before joining Amerigroup in 2012, he was the vice president and medical director for New York’s former Health Plus managed care plan — acquired by Amerigroup that same year.

Dr. Ackman is board-certified in internal medicine and holds a master’s in public health from Columbia University.

We’re Looking for a Few Great Physicians.

To join the AQMC, call Dr. David Ackman at 718-840-4642 or email your contact information to david.ackman@amerigroup.com.
Member Rewards for Health

Early detection is invaluable to protecting our members’ health and improving their quality of life. With our Member Rewards for Health program, it can be valuable to their wallets, too.

Members can earn up to $50 in gift cards from Target, Visa, Wal-Mart and other retailers when they visit you for these preventive care services:

- Flu and pneumonia vaccinations
- Annual wellness visits
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Diabetes screenings
- Glaucoma screenings (every two years)
- Bone mass measurements
- Smoking cessation
- Mammographies
- Prostate cancer screenings

Remind members to bring their Rewards for Health reply cards to their appointments. You’ll need to sign their cards for each service completed. When members mail us their signed cards, they’ll receive $10 gift cards for each eligible service completed (up to $50 for the calendar year).

Cultural and socioeconomic concerns influence help-seeking behaviors and attitudes toward health care providers and services. Belief systems associated with health, healing and wellness are as diverse as the populations we serve.

Cultural Competency training is required to remain a provider in good standing with us and gives you and your staff tools to better understand and help our members.

Take our no-cost online training today through our provider self-service site.
Our Provider Billing Integrity (PBI) department compares the use of billing codes across like specialties and markets to ensure services are billed to the correct codes and eliminate up-coding.

This helps prevent waste, fraud and abuse, and saved Amerigroup $6.2 million in 2011 — a saving we can ultimately pass on to the states and taxpayers who fund Medicaid plans.

For more information, call the PBI department at 1-866-696-2675.