

SECTION L: MEMBER TRANSITION

L.1 Coordination of Member Transition

L.1 Describe how you will coordinate transition of a member in the following scenarios to minimize member disruption and ensure continuity of care:

- *From one managed care entity to another (receiving and relinquishing a member); and*
- *Between fee-for-service to/from your MCO.*

Your processes should address interactions with and processes for engaging existing providers in the transition

One of Amerigroup Louisiana's (Amerigroup) core competencies is our ability to seamlessly support continuity of care during member and provider transitions. Our processes to transition members while assuring that continuity of care and services comply with all applicable State and federal requirements. We recognize that any type of transition can potentially be stressful for members, so we work with them every step of the way to make sure they have the information and supports in place to prevent disruption in care.

We have developed comprehensive policies and procedures that provide the structure and resources needed to effectively transition to or from another managed care entity, another provider, or fee-for-service Medicaid. We will work closely with the member's new or previous MCO, program administrator, and/or providers to facilitate a smooth transfer or prior authorization information, care plans, treatment plans, and other pertinent information. Our processes comply with all applicable State and federal requirements.

In July 2014, Amerigroup successfully transitioned more than 30 members with specialized health care needs requiring home and community-based services and supports who opted out of the Louisiana HCBS Waiver Program. 🌸

Member Transitions from One MCO to Another

Coordinating care is a critical part of a member's treatment. When a member transitions from Amerigroup Louisiana to another MCO, we work with the plan to provide a clinical summary of information that includes:

- The member's care plan, if he or she is enrolled in case disease management
- A listing of prior authorized services
- The member's medication summary
- The member's primary care physician's or any other specialty providers' contact information and treatment plan summary

Our Nurse Medical Management team coordinates benefits and services across managed care plans to verify that all gaps in care and services are identified and resolved, regardless of which plan pays. This includes coordination of shared case planning and regular care conferences to sync services for each member as needed. We are already adept at such coordination for members with special health care needs, whom we serve today, and collaborate with the other benefit plans in our regions to develop a plan for seamless transition and coordination of care.

When a member transfers from another MCO to Amerigroup, we will:

- Obtain notification of the member's transfer from the MCO

- Evaluate the member's immediate health care needs through outreach and screening, then implement coordination and care management, as needed
- Review clinical information received from the MCO
- Contact the member's primary care provider or specialty provider to coordinate care
- Document the member's information in our clinical management system

Upon notification of the member's transfer to Amerigroup, we will begin establishing a positive relationship with the individual. ***Our goal is to quickly engage members in the services and supports they need, encouraging appropriate utilization of services, and giving them the information they need to learn to self-manage.***

Member Transitions from Fee-for-Service to Managed Care

Through our experience, we know that engaging members early on enables us to better achieve improvements in health outcomes. Through early identification, assessment, and care plan development, we can successfully transition new members to managed care. Our processes for transitioning new members include:

- Informing new members of program benefits through DHH-approved welcome materials
- Conducting follow-up welcome calls to engage new members and identify immediate or existing health care needs – an opportunity to engage, build a relationship, and obtain health-related information
- Evaluating members as soon as possible to determine their medical, functional, and behavioral health status
- Prioritizing outreach and assessment according to the member's risk levels (so that those with the most imminent needs are assessed quickly)
- Identifying the appropriate level of care coordination stratification and engagement
- Identifying members' primary care provider or connecting them to one
- Obtaining and incorporating existing care plans and other information, such as previously completed assessments, into our clinical system
- Holding town hall meetings throughout Louisiana communities to engage members and their families, giving them the opportunity to be introduced to Amerigroup, ask questions, or voice concerns

We have an effective process in place that supports seamless transition of members with pre-existing care plans. When we receive information on approved prior authorizations and current care plan, we incorporate this information into the member's record to help our clinical staff determine continuity of care needs.

While our procedures for MCO and fee-for-service (FFS) transitions are very similar, we realize members and providers who have not previously participated in managed health care may experience a higher level of anxiety and stress associated with the transition. As a result, we provide detailed, accessible information to those in FFS programs about the member's option to remain with an out-of-network provider until we can contract that provider into our network or complete a comprehensive assessment and help identify a new one who can meet the member's needs.

Promoting Continuity of Care during Transition

For Amerigroup, continuity of care does not merely mean honoring the services the member is receiving at the time of transition. It means identification and delivery of care that is holistic, continually assessed

for appropriateness, adjusted as necessary, and monitored for outcomes. Our established continuity of care guidelines include systems and processes for facilitating seamless member transitions from FFS to managed care, one MCO to another MCO, or from one provider to another. We describe each of the critical components of our approach to facilitating continuity of care for all members in the table below.

Table L.1-1. Components of Effective Continuity of Care

Component	Description
Authorizations	We honor all existing authorizations, including those with external organizations providing carved-out services, and frequency of service identified on the member’s care plan for up to 90 days following enrollment. During this time, case managers complete an assessment as needed and develop a new care plan with the same or alternate services and supports based on the member’s holistic needs. Case managers continually monitor the member’s progress and continued need for authorized services. Our clinicians complete the necessary prior authorization requests to prevent disruption in care.
Transportation	To support a smooth transition and minimize potential anxiety, Amerigroup clinicians discuss the need for transportation with the member and family or caregivers during the transition call or case management assessment. Our clinicians arrange for initial and/or on-going transportation through our non-emergency medical transportation (NEMT) vendor and add the service to the member’s care plan.
Non-Contracted Providers	Our clinical team identifies members receiving services from out-of-network providers and contacts our Provider Relations department for outreach and contracting. If we are unable to contract with the provider for any reason, we work closely with the member to choose another provider or, in the best interest of the member, we work with the provider to establish a single-case agreement to provide on-going care. We do not enter into single case agreements with any provider that has sanctions.
Care Plans	Case managers review new members’ care plans for appropriateness of care, arrange for all medically necessary services, and identify any gaps in care. Case managers review and honor new members’ care plans. We complete a thorough review that supports the existing care plan or work with the member, family members, caregiver, and providers to develop a new care plan. We identify any gaps in care and refer the member for additional services, if needed.
Multi-disciplinary Clinical Rounds	Under the direction of our chief medical officer, our clinical case rounds include multi-disciplinary participants from departments across the health plan, including utilization management, case management, chronic care/disease management, and behavioral health case management. Case rounds are conducted weekly to discuss complex cases, identify gaps in care, obtain clinical consultation from our Chief Medical Officer and Behavioral Health Medical Directors on chronic conditions, and address barriers to access.
Behavioral Health Rounds	In addition to complex case rounds, our Behavioral Health Medical Director leads clinical rounds biweekly. During these rounds, complex cases are reviewed to make sure interventions are appropriate and timely.

Component	Description
	<p>The team evaluates each case to identify and resolve any barriers to reaching goals, such as co-occurring conditions, language, medication adherence, transportation, or family issues.</p>
<p>Timely and Accurate Information</p>	<p>Our clinical support tool, Member 360^o, combines member data and information from various sources into a single record to provide a holistic picture of the member’s utilization, care management services and gaps in care. It includes such information as member Health Risk Assessments, care plans, longitudinal member health records, and clinical data.</p>
<p>Dedicated Case Managers</p>	<p>During the initial assessment, case managers take time to get to know the member; learn about his or her preferences, family, and supports; and identify and understand the member’s needs. By proactively obtaining a copy of the member’s plan of care, past assessments, and open service authorizations, and through outreach to the providers with established relationships with the individual, the case manager lays the foundation for continuity of care.</p>
<p>Transition from Inpatient Facilities</p>	<p>We recognize that members who are transitioning between plans during an inpatient stay are faced with an additional challenge to coordination of care. Amerigroup currently co-locates Nurse Medical Management employees at key hospitals to work closely with case managers assigned to members upon hospitalization to initiate discharge planning. Upon identification of a member who is hospitalized, our co-located Nurse Medical Management clinician conducts the following activities:</p> <ul style="list-style-type: none"> • Notifies the case manager • Initiates concurrent review • Works closely with the care team, including the member, family, caregivers, hospital employees, the case manager, and providers to develop a discharge plan • Meets with the case management team twice weekly to discuss the member’s progress • Identifies any gaps in care and barriers to accessing the services needed to support a safe and timely transition to the community <p>The case manager is responsible for confirming completion of the discharge plan, identifying any gaps in services and supports, scheduling post-discharge follow-up appointments, and participating in the member’s transition home or to the community as needed.</p>

Engaging Providers in Transitions to Support Continuity of Care

Amerigroup collaborates with providers to assure continuity of care during a member's transition period. We facilitate confidential exchange of information between primary care providers (PCPs) and specialty providers, including behavioral health. We support effective communication and appropriate information sharing through:

- **Promoting Provider Coordination of Care.** We encourage and work with providers to communicate clinical findings, treatment plans, prognosis, and the member's psychosocial condition as part of the coordination process. Our clinical team reviews member and provider requests for continuity of care and facilitates continuation with the current provider until a short-term regimen of care is completed or the member transitions to a new practitioner.
- **Encouraging Communication Among Providers.** Our clinical team coordinates care and facilitates communication and information sharing among PCPs and specialists, as well as external case managers. Our case managers will link multiple providers and make sure that all care is coordinated and documented in our clinical system.

Throughout the transition, case managers involve the current and new providers in developing and implementing the member's transition plan. It clearly outlines the responsibilities of each provider and timelines for completing member transition activities, facilitating a seamless transition for the member.

L.2 Approach to Meeting Newborn Enrollment Requirements

L.2 Describe your approach to meeting the newborn enrollment requirements, including how you will:

- *Encourage Members who are expectant mothers to select an MCO and PCP for their newborns;*
- *Ensure that newborn notification information is submitted, either by you or the hospital, to DHH or its Agent within twenty-four (24) hours of the birth of the newborn; and*
- *Ensure that the birth is properly recorded in the Louisiana Electronic Event Registration System (LEERS).*

Amerigroup understands the importance of early preventive maternal and prenatal health care. We work daily to promote and improve the health and well-being of women, infants, children, and families. Our maternal-child health program builds an array of services that promote better health outcomes for mother and baby. Predictive models and prenatal risk assessments identify women with the highest risk levels so that we can apply a matching level of support, such as in-home services and community-based interventions.

To identify our members who may be pregnant or have a newborn, we use a variety of information, such as:

- Two years' worth of claims data provided by DHH to identify transitioning members who may be pregnant
- Information generated from our new member welcome call or OB risk screening call that indicate a pregnancy or recent birth
- Daily review of State eligibility and enrollment files
- On-going information and report generation from health plan departments, such as Member Services, Nurse HelpLine[®], case and medical management, provider relations, Member Advocate, and quality management

Amerigroup also uses retroactive claims data analysis to identify existing or potential risks to members who are pregnant or have a newborn, such as substance use treatment or poly-pharmacology.

Encouraging Expectant Mothers to Select an MCO and Primary Care Provider for Their Newborns

Amerigroup complies with newborn enrollment requirements outlined in Section 11 of the RFP. We identify and outreach to expectant mothers at least 60 calendar days prior to their expected delivery date to encourage them to choose a PCP for their newborn. Our Member Service Representatives conduct welcome calls and work with each woman to provide information about her benefits, rights and responsibilities, and available services and supports. We inform members of their voice and choice in choosing an MCO and PCP, as well as the process for changing them. We encourage and support members in selecting PCPs that best meet their needs, such as cultural, linguistic, and geographical consideration, as well as any special health needs.

If the mother has not chosen a PCP for her newborn, ***Amerigroup will auto-assign a PCP within 24 hours of being notified of delivery or communication with the mother.*** Amerigroup mails written

notification of the auto-assignment to the mother via an identification card within 24 hours of birth, as well as information on requesting a change in MCO and/or PCP.

To make sure appropriate services are provided upon birth, all newborns are temporarily enrolled in our eligibility system immediately upon notification. The temporary record is reconciled when the child's permanent Medicaid ID is received on the enrollment file from DHH. We have an integrated, standardized process to reconcile temporary records with the permanent Medicaid IDs received from DHH.

Should a newborn be admitted to the Neonatal Intensive Care Unit (NICU), our co-located Nurse Medical Management clinicians engage with the mother to encourage selection of a PCP or other provider that specializes in the needs of her child. If a newborn child leaves the hospital without a designated PCP, Amerigroup Nurse Case Managers conduct telephonic and/or in-person outreach to the member to identify any barriers to provider selection based on the mother's and child's risks.

Newborn Notification within 24 Hours of Birth

Amerigroup contractually requires our network hospitals to submit a notification of birth within 24 hours via DHH's web-based Request for Newborn Manual system, which generates a request for a Medicaid ID for the newborn. Our contracted hospitals are required to provide the mother's PCP selection for the newborn (if made) and register all births through the Louisiana Electronic Event Registration System (LEERS), in accordance with State requirements.

Upon identification of any hospital subcontractor that fails to notify Amerigroup of a birth within 24 hours, our provider relations employees conduct a training outreach on notification requirements and processes. Continued failure to provide timely notification will result in provider a corrective action plan and possible removal from the Amerigroup provider network as appropriate.

Ensuring Proper Recording of Birth in the Louisiana Electronic Event Registration System

Amerigroup has established processes for requiring notification of birth and the proper recording of births in LEERS. Upon notification from members, providers, hospital personnel, and/or Amerigroup co-located Nurse Medical Management clinicians that a child has been born, Amerigroup contacts the hospital-specified representative responsible for registering the birth in LEERS for confirmation. If the birth has not been recorded, we formally request the documentation, escalate the lack of documentation to the appropriate hospital supervisor, engage our provider relations team, and/or notify the State of continued issues as appropriate.

L.3 Interventions to Prevent Member Disenrollment

L.3 Describe the types of interventions you will use prior to seeking to disenroll a Member as described in an MCO-Initiated Member Disenrollment, Section 11 of this RFP. If applicable, provide an example of a case in which you have successfully intervened to avert requesting the disenrollment of a member.

Whether based on member request or Amerigroup's internal policies, we look at potential disenrollment as an opportunity to develop new, innovative programs that meet our members' needs. Consequently, we review, adjust, or eliminate our processes or policies that create barriers to our members engaging in their own health care. Amerigroup's primary goal is to support our members' voice and choice in their health care decisions, which includes honoring their requests for disenrollment from our Louisiana Bayou Health program. Amerigroup will disenroll members only in cases of fraud or abusive behavior in provider offices.

We have a variety of tools, resources, and supports that are effective in connecting members to the benefits and services they need. We strive to inform and empower parents, guardians, and members on how to use Amerigroup benefits, how to access services, and the importance of preventive care. Our goal in supporting members is always to improve member behavior and avoid unnecessary disenrollment that can disrupt continuity of care for those who need it most.

Amerigroup and our affiliate health plans in 18 other states promote the appropriate use of services and maintain our position as a steward of precious health care resources. We are committed to serving our members and work closely with members and all providers involved in their care to address inappropriate utilization or behavior, effectively averting disenrollment. Once we identify behavior that may be problematic, we educate and support members to make appropriate choices and, as necessary, may require them to work only with specified providers.

Identifying Suspicious Activity

Amerigroup routinely analyzes member and provider utilization data to determine over- and under-utilization of services, as well as identify potential fraud or abuse. Providers are encouraged to contact us for assistance if they discern member behavior that may indicate a problem.

- **Data Review:** We review existing data and establish any necessary reporting that enables us to identify patterns of behavior outside of the norm. For example, routine review of utilization data will identify patterns of overutilization while anti-fraud software may help us identify cases of fraud and abuse.
- **Referral:** Referrals are reported to Amerigroup via multiple avenues, including mail, telephone, in-person contact, email, Internet, Intranet, or our compliance hotline. Referrals can come from members, providers, employees, law enforcement agencies, and professional organizations. As an example, a provider may call to report a member who has demonstrated a pattern of disruptive, unruly, abusive, or uncooperative behavior not caused by a physical or mental condition. We then determine whether the behavior seriously impairs our ability to furnish services to the member or other members.

In all circumstances, we first work with the member and provider to address the inappropriate behaviors and engage the individual in services and supports.

Engaging and Supporting Members in Healthy Behavior

Once we determine that a member may need assistance to appropriately engage in his or her health care, we take immediate action to provide that support.

We employ a broad communications approach to encourage compliant member behavior, using such mechanisms as member handbooks and newsletters, inserts included with the explanation of benefits, one-on-one member education during care management contacts, and information furnished by providers to members at the request of our Care Managers. These methods integrate fraud and abuse education and prevention into our regular service and business processes/practices, and involve all stakeholders in assuring optimal use of resources.

Amerigroup tailors a care management approach that provides coordinated services and individualized education to address the member's unique physical, behavioral, social, functional, and environmental needs.

Our care management model promotes member wellness, preferences, and empowerment through a coordinated program of advocacy, communication, education, identification of service resources, and service facilitation.

Our case manager will work with the PCP and any other treating professionals involved in the member's care, **including behavioral health, and home and community-based providers**, to develop an individualized care plan that will help the member address his or her behaviors. The care plan will also include all supportive services and resources required to meet the member's needs. The care plan is aimed at achieving treatment goals and addressing any barriers to the improvement of the member's quality of life. It may also include a combination of telephonic care management services and those delivered directly by a multi-disciplinary team. Ultimately, the goal is to define and address all medical, behavioral, and social service needs, including educating the member about compliant behavior.

We recognize that some members will require close coordination through our care management program to encourage appropriate behavior, and we will involve all appropriate providers in that process to help alleviate non-compliant behavior. All member contact is documented during this process.

Interventions to Support Members and Providers in Care Coordination

If a member does not respond to our care management program and continues to demonstrate inappropriate or non-compliant behavior, we will work with the individual and providers involved to limit the member to specific providers that meet the member's needs. Depending on the issue, members may be limited to a physician, physician group, nurse practitioner, clinic, outpatient setting, hospital, dentist, dental clinic, pharmacy, alternative pharmacy, and/or durable medical equipment supplier.

Amerigroup will continue to provide the member with reasonable access to quality services with consideration given to both geographic location and travel time. We will not restrict member access to emergency services under any circumstances.

Our case managers will support the member through routine assessments to confirm that the individual is receiving appropriate services and supports. The case manager also maintains on-going contact with providers to coordinate care and facilitate communication. As needs change, we will evaluate any on-going need to limit providers.

Once we determine that a member may need assistance to appropriately engage in his or her health care, we take immediate action to provide that support. 

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