

## SECTION I: MEMBER ASSESSMENT AND CARE COORDINATION

### I.1 Continuation of Medically Necessary Services for Members with Special Health Care Needs

*I.1 DHH intends to provide MCOs with two years of historic claims data for members enrolled in the MCO effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your MCO effective February 1, 2015. The description should include:*

- *How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services;*
- *What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;*
- *How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;*
- *What information, education, and training you will provide to your providers to ensure continuation of services; and*
- *What information you will provide your members to assist with the transition of care.*
- *Describe your approach to identifying “hot spotters” who are high utilizers and describe any innovative approaches you utilize to be able to identify the difficult to find patients.*

Amerigroup Louisiana successfully transitioned the care of more than 120,000 members, including members with specialized health care needs, to our Louisiana Bayou Health program through August of 2012. Throughout the transition and when serving members in local communities across Louisiana, we developed positive relationships with system partners, providers, and members in each region. We have embraced the lessons learned from this transition and stakeholder feedback to improve our processes, policies, and procedures for the continuation of services for all members in our program. We employ a member-centered approach to care coordination that facilitates continuity of care and supports members in achieving their recovery goals. We do this by proactively identifying members with special needs or new, unmet, or undiagnosed needs and coordinating services across providers and system partners to meet the whole health needs of each member.

***Amerigroup’s member-centered vision is the cornerstone to our care coordination approach that provides each member with the services and supports needed to improve his or her health, wellness, and quality of life.***

We illustrate our approach to care coordination for our members, including those with specialized health care needs, in *Figure I.1-1. Member-Centered Model of Care for Members in Amerigroup’s Louisiana Bayou Health Program*

Figure I.1-1. Member-Centered Model of Care for Members in Amerigroup’s Louisiana Bayou Health Program is Multi-faceted



## Identifying Members with Special Health Needs

As an existing health plan serving members in Louisiana, Amerigroup has effective systems and processes in place that incorporate the use of DHH data to proactively identify and support members with special health needs. Our **established processes, robust systems, and experienced people** support early and effective identification of members with special health needs and members with new, unmet, or undiagnosed needs, including the following:

- Persons with physical and/or mental health disabilities
- Members in the Chisholm Class
- Recent inpatient admissions including physical and behavioral health facilities
- Frequent use of Emergency Department (ED) services
- Reproductive-aged women who are expecting or recently delivered a child with a poor birth outcome
- Children not participating in such services as EPSDT visits, annual well checks, dental care, and early intervention screening
- Co-occurring physical and behavioral health diagnoses
- Existing or potential chronic care or disease management needs
- High or concerning utilization of pharmaceuticals, such as two or more prescriptions in one drug classification
- Members receiving care through external organizations, including behavioral health, dental, and home and community-based services (HCBS)

Through our predictive modeling tool, we proactively identify members who may need additional support. We also identify members with special needs through new member welcome calls, the assessment process, our “no wrong door” approach, and network providers. Our multi-faceted, proactive approach allows us to intervene quickly and engage members in preventive care, promoting a seamless transition to Amerigroup without disruption of on-going services and supports.

## Predictive Modeling

Using the retrospective two-year claims data provided by DHH, Amerigroup identifies members new to the health plan who may have initial or on-going high-risk, complex, chronic, or co-occurring needs and those members who may need additional support or referral during and after transition. We review provider types, procedure codes, dates of service, and other indicators, as well as data provided by external organizations providing carved out services such as specialized behavioral health services, dental care, and HCBS.

Each member is assigned a Chronic Illness Intensity Index (CI3) score that quantifies a member’s relative predicted cost in the next year compared to the average Amerigroup Medicaid member. This tool allows us to stratify all members appropriately based on their level of risk for adverse outcomes. We can then identify members with special health needs and conduct outreach to provide them with the services and supports they need for positive health outcomes.

***For those members with the most complex needs, we employ a second predictive model.*** This model, the Likelihood of Inpatient Admission (LIPA), ranks members based on their chance of being admitted to the hospital in the next 60 days. We use the LIPA score to prioritize member outreach by a case manager. Our predictive modeling system uses member data—including diagnoses, demographic information, and recent inpatient and ED utilization history—from historical and current claims to develop individualized scores each month.

All members have a clinical profile generated on a monthly basis to track changes in their health status and outcomes, allowing us to meet members’ changing needs swiftly. These individualized clinical profiles contain information about each member, including demographics, contact information, CI3 and LIPA scores, coexisting conditions, utilization data, and recent care coordination information.

Amerigroup case managers access member profiles via a powerful tool that prioritizes members based on the predicted level of case management need. This information directs our care coordination efforts toward a timely and appropriate plan of care so that our members receive the right care at the right time with the right support. As a member’s CI3 or LIPA scores change (increase or decrease), we adjust the level of support the member receives based on his or her intensity of need.

### NEW MEMBER SATISFACTION

**New to Amerigroup’s Louisiana program, Maria, during her welcome call, said she was thinking of switching plans because her PCP was not in the network. Our Member Services representative explained that she could continue to see her provider for now and that a case manager would call her to discuss her options. Our case manager reviewed Maria’s benefits and all available providers in our network with her. The case manager also offered to reach out to her current PCP to discuss contracting options. Maria was satisfied with how we addressed her concerns and actually decided to select a PCP that was closer to her than her previous provider. 🌸**

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### New Member Welcome Call

Amerigroup recognizes the importance of engaging members quickly upon enrollment into our plan. ***Within 14 days of sending the welcome packet, we conduct New Member Welcome Calls using our DHH-approved script to engage new members and identify immediate needs and existing or potential specialized health care needs.*** New Member Welcome Calls give us the opportunity to establish a positive relationship with all new members and to learn more about our members' needs so we can support them in achieving positive health outcomes and improved quality of life.

Our New Member Welcome Call DHH-approved script is designed to encourage members to share health-related information such as diagnoses, current health status, services and supports, history of ED use and inpatient admissions, living environment, and social and natural supports that may indicate complex, chronic, co-occurring, and comorbid conditions. We train our member services employees in cultural competency and motivational interviewing to promote sensitivity and understanding during the New Member Welcome Call to maximize member comfort and sharing. If we identify any members with specialized needs during the welcome call, our member services employees make a referral to our case management team for further outreach, screening, assessment, and referral, as appropriate.

As part of our New Member Welcome Call, we conduct an initial Health Risk Assessment on all members. ♣

Amerigroup recognizes that members with specialized needs may be difficult to reach at times. As a result, if we are unable to reach a new member after three attempts, we mail a letter directly to the member, offering assistance and providing a phone number for him or her to call for assistance. We will notify DHH on a monthly basis of our members who are difficult to reach.

### Member Assessment

***We refer new members identified as having potential or actual high-risk, complex, chronic, or co-occurring needs to our case management program for further assessment by clinical employees.***

Amerigroup's nurse case managers are licensed health care professionals, such as registered nurses (RNs), RNs with behavioral health and social work expertise, licensed clinical social workers (LCSWs), or licensed professional counselors (LPCs) with the experience and expertise to assess our members' needs and to incorporate self-directed improvements in their health, well-being, and quality of life.

After establishing contact with the member, our nurse case manager completes an initial, integrated, comprehensive clinical assessment using a standardized, best practice tool. The nurse case manager assesses the member's total health care needs holistically, including physical, behavioral, functional, cognitive, and social factors, as well as access to care. This process allows us to not only identify members with special health needs, but also to put the services and supports in place to meet those needs, improving their health and wellness.

### "No Wrong Door"

Our "no wrong door" approach supports identification of members with special health needs through multiple sources, including members, families, providers, screening tools (such as EPSDT forms), as well as internally from any department, such as Member Services, Concurrent Review and Discharge Planners, or Prior Authorization. Once the member is identified as potentially having special health needs, we conduct a comprehensive assessment to determine the level of support the member needs to achieve their recovery goals.

## Network Providers

Amerigroup recognizes that our network providers are a primary resource for identifying members with special health needs. We require our providers to screen for symptoms that may indicate potential specialized health care needs during every appointment with members on their panel and to refer members to our case management program, as appropriate. We train providers and give them the screening tools they need to appropriately screen, identify, and refer members with special health needs.

For example, over half of patients seek treatment for behavioral health conditions from their PCPs, resulting in non-psychiatrists writing more than three-fourths of antidepressant prescriptions. Amerigroup proposes to implement the PC-INSITE program for our Bayou Health population to improve the detection, diagnosis, treatment, and on-going management of persons experiencing depression and/or a substance use disorder (SUD). The PC-INSITE creates supports within the primary care setting to enhance the PCP’s tools to diagnose and treat behavioral health conditions such as depression and substance use disorder. ***This whole-person approach gives patients the care they need in a single location while reducing morbidity and costs.*** The vision of PC-INSITE is to within primary health services detect, identify, and intervene with individuals experiencing depression. Depression affects and complicates treatment of other health conditions; effective treatment of depression improves overall health delivering ***better health outcomes.***



Through the implementation of PC-INSITE, Amerigroup seeks to achieve the following:

- Improved management of a person’s depression/SUD health, including other co-occurring conditions
- Enhanced health experience for the individual
- Improved the health outcomes for the practice
- Lower health services costs

In addition to these overall program goals, the PC-INSITE Program will provide benefits to participating primary care practices:

- Increased capacity to screen, assess, and treat patients with depression
- Enhanced treatment of physical disease and conditions like depression can affect recovery and treatment response
- Access to a Behavioral Health Coach to support patient treatment of depression

## Additional Information from DHH to Support Continuation of Services

Amerigroup will use the two years of historical data provided to us by DHH to understand the prevalence of special health, co-occurring, and disease needs of our members. We will also use the data to identify members’ services to assure continuity of care. Based on our experience serving members in Louisiana and across the country, we have also identified supplementary data that will support continuity of care for members during the transition, facilitating a seamless transition.

Table I.1-2 *Supplemental Data Requested by Amerigroup to Support Continuity of Care* illustrates supplemental data we are requesting from DHH to assist in the early and accurate identification of members who may need additional support when transitioning to our health plan. We recognize that some information may be more readily available than other, and will remain flexible in working with DHH to prioritize those elements that have the greatest impact.

Table I.1-1 *Supplemental Data Requested by Amerigroup to Support Continuity of Care*

Supplemental Data	Description
Open Authorizations	Details on any current authorizations for covered services or benefit (Including HIPAA-compliant 278 Files)
Average Daily Census	Daily summary level statistics of members admitted to each facility
Detail Daily Census	List of inpatient admissions
Pregnant Women	List of pregnant women who are due to deliver, who have experienced a prior poor birth outcome, and with a high-risk infant admitted to the NICU
Case Management	List of members who are currently in case management or are candidates for case management who have not been contacted
Chronic Care/Disease Management	List of members who are currently enrolled in any disease management programs
Recent/Planned Transplants	List of members who have had a transplant within the past three months or have a planned transplant in the future
Members with Specialized Health Care Needs	List of members with specialized health care needs
Members assigned PCPs	List of current members and their assigned PCPs

Amerigroup believes this list represents the optimal array of data that would best support and facilitate a smooth transition through the rapid identification and engagement of members with greater needs. As always, we are fully prepared to implement our program with any and all data DHH is willing to provide.

### Promoting Continuity of Care

For Amerigroup, Continuity of Care does not merely mean honoring the services the member is participating in at the time of transition. It means the 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 provider. We describe each of the critical components of our approach to facilitating continuity of care for all members in *Table I.1-2. Components of Effective Continuity of Care.*

*Table I.1-2. Components of Effective Continuity of Care*

Component	Description
Authorizations	We honor all existing authorizations with the same provider, 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 request to prevent disruption in care.
Transportation	To support a smooth transition and minimize potential member anxiety, Amerigroup clinicians discuss the need for transportation with the member and the member’s 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 not able to contract with the provider, we work closely with the member to choose another provider; or, if 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 providers who have 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. They review and honor new members’ care plans. Amerigroup completes 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 interdisciplinary 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 Director 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. 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.

Component	Description
Timely and Accurate Information	Our clinical support tool, Member 360° <sup>SM</sup> , 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. Member 360° <sup>SM</sup> includes such information as member health risk assessments, care plans, longitudinal member health records, and clinical data.
Dedicated Case Managers	During the initial assessment, case managers take the time to get to know the member, learning 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 member, the case manager lays the foundation for continuity of care.
Transition from Inpatient Facilities	<p>We also plan for Continuity of Care for new members who are hospitalized at implementation. 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"> <li>• Notifies the case manager</li> <li>• Initiates concurrent review</li> <li>• Works closely with the care team, including the member, family members, caregivers, hospital employees, the case manager, and providers to develop a discharge plan</li> <li>• Meets with the member’s case management team twice weekly to discuss the member’s progress</li> <li>• Identifies any gaps in care and barriers to accessing the needed services that support a safe and timely transition to the community</li> </ul> <p>The case manager is responsible for confirming the completion of the discharge plan, identifying any gaps in services and supports, scheduling post-discharge follow-up appointments for the member, and participating in the member’s transition home or to the community as needed.</p>

## Provider Information, Education, and Training

Amerigroup actively educates and engages our network providers about their role in facilitating effective, efficient, and seamless transition of care for all members, whether the member is transferring from an existing health plan or from another in-network or out-of-network provider. We inform and educate providers through on-going trainings, materials, and coaching sessions with staff, and give providers access to tools and resources to effectively support members during transitions.

With continuity of care being our primary goal, our collaborative transition education program informs providers on our established guidelines in the following ways:

- Required orientation and on-going, ad hoc, annual, and targeted trainings
- Provider handbook, integrated screening tools, community-based resources, authorization referral processes, and other key resources located on our web-based provider portal
- Case management and disease management staff
- Provider relations representatives
- Utilization management employees
- Provider newsletters and fax blasts

Our Amerigroup provider communication tools also includes a comprehensive provider web portal through which all providers can view information on care coordination tools. We offer a variety of monthly provider training meetings, webinars and personalized help to give providers the information and tools necessary to deliver services. Our PCP training and online resources educate them about screening members for behavioral health and psychosocial needs and how to connect the member to supports. We use a community-based approach to support and educate our providers on how to assist members during transitions. We follow up with providers by providing actionable information that allows them to track member progress and identify members in need of outreach and engagement.

### Community-based Provider Outreach and Education

In addition to our robust provider training program, we take a high-touch approach to educating and supporting providers. We employ an on-the-ground approach to provider education, in which we facilitate communication and build trust through tailored approaches that meet the unique needs of different provider types. We are out in the community, meeting daily with providers in their offices and facilities to make sure that we address their needs and answer their questions, and work collaboratively to build successful provider relationships.

**We are in the community daily meeting with providers in their offices and facilities to make sure we are addressing their needs, answering their questions, and working collaboratively to support members.** 🌸

We have the personnel, systems, and processes in Louisiana to deliver local, quality customer service to our providers. Our on-the-ground approach facilitates communication and builds trust. We believe that timely and accurate response to providers is essential to building successful provider partnerships. ***We make it easy for providers to reach us through the provider services line, cell phone, email, website, and fax.*** We are in the community daily, meeting with providers in their offices and facilities to make sure we are answering their questions, addressing their needs, and working together.

To support member transitions and promote continuity of care, our Provider Relations team assists all high-volume facilities in developing transition plans for members who may be in the hospital on our go-

live date. Working directly with facility staff, including its discharge planning teams, Amerigroup identifies affected members and immediately begins planning for each member’s safe transition from inpatient care to his or her home or other community-based setting.

### Providing Actionable Data through Member 360<sup>SM</sup>

Amerigroup supports member voice and choice in what happens to them and their health care. 

Through the *provider-facing* Member 360<sup>SM</sup> tools, providers who have members attributed to them can see the member record via the Amerigroup provider portal giving them simple, easy-to-access data and information to assist them in *engaging the member in his or her health and well-being*. The integrated data will be displayed to make it easy for providers to act on it and make sure their patients

are getting the services they need. This view will enable any provider who is treating our members to see the full picture, including care plans and assessment information, enhancing their ability to reduce duplication and improve their quality of care. The provider view will enable them to understand, from a population health perspective, how their members are doing and more important, give them information that helps them achieve better results. Our platform will support the providers in achieving the quality incentives defined in the Amerigroup quality programs. For example, the provider will be able to search the patients with diabetes to see their most recent HbA1c results. The tool will take the providers to the next level by delivering much more than data—instead it gives them information that is synthesized and displayed in a succinct view to create obvious, actionable items right in front of them.

### Assisting Members with Transitions of Care

Amerigroup is committed to connecting members with the services they need, when they need them, and in the setting they choose. We recognize that our members’ needs change frequently and supporting them during critical transitions between care settings is one of the most crucial care coordination functions.

These transitions exemplify some of the most vulnerable times for our members; therefore, our case managers are dedicated to facilitating safe and successful transitions between health care settings for our members.

We support member voice and choice in what happens to them and their health care. We help our members prepare for transitions before they occur by providing information on continuity of care, coordination of care, and how they can access supports through the following:

- New member welcome call
- Telephonic or in-home outreach by case managers
- Member handbook
- Member website
- Network providers
- Referral process information to services that are provided by external organizations
- Print materials such as brochures, fliers, and targeted mailings

#### COORDINATING WITH PROVIDERS

**Diagnosed with oral cancer, Jules just had a catheter placed for chemotherapy treatment when she learned that her physician would no longer be able to treat her. With her permission, the case manager called the practice office and discovered that, while the facility where Jules had her procedure was in-network, the physician was not. Everyone worked together to find the most appropriate local provider for her, scheduled an appointment, and made sure Jules’ records were sent to her new physician.**

**Jules is very pleased with her new provider and found a PCP in that same group of physicians. Her new team of providers consistently communicates and collaborates with her, which has improved her physical and emotional well-being.** 

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We also train our staff to educate and inform members of available supports through every interaction. Our goal is to promote engagement by giving them information in a way that best meets the member's needs, strengths, and preferences.

During the transition period, our case managers provide one-to-one member coaching and education on strategies for successful transitions. Case managers:

- Assess the member's health status to proactively determine changes in the member's condition
- Complete a comprehensive needs assessment when members experience a change in condition to make sure that the plan of care continues to meet member's needs and make adjustments to services and service settings as needed
- Collaborate with the member, his or her family/caregiver, facility staff, and providers to develop an effective transition plan
- Share information and obtain input from the member's PCP and specialty physicians
- Update the member's plan of care to reflect his or her current health status, needs, and preferences
- Make referrals for services and assist with scheduling caregivers and physician appointments
- Assess key transition components, including medication management, nutrition, adequacy of the service plan, and physician follow-up after the transition is completed to provide additional support and education based on their evaluation of the member's health status, and identified gaps in care.

Our foremost concern during all member transitions is the health and safety of our members within the context of their recovery goals. We have developed specific processes to support member transitions, including transitions to and from a nursing facility and community settings, transitions out of the hospital setting, and between levels of care.

## Identifying Members with High Utilization of Services

Amerigroup seeks to identify members with the potential for high utilization of services to quickly intervene, providing the member with support, and connecting them to preventive care. We proactively mine utilization data and data provided by DHH using the Chronic Illness Intensity Index (CI3), our

### EMPOWERING OUR MEMBERS

**Peter, a 22-year-old with high blood pressure, was not seeing his PCP but was frequenting the ED. He was referred to a case manager and found he had reading, writing, and comprehension challenges, which resulted in his dependence on others for his shopping and getting to his PCP visits. Peter had also recently been robbed of his money and prescription medication. Peter and his case manager worked together so he could better understand his condition, found and scheduled an appointment with a local PCP, and arranged transportation to his appointments. They also identified a family member who could help him with his personal needs, including paying bills and managing his medicine. Peter now attends his PCP appointments without disruption and has not visited the ED since he enrolled in case management.** 🌸

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predictive model, to identify members with high rates of utilization. We also continually analyze ED utilization patterns to understand which members are most likely to have avoidable ED visits. Within our suite of predictive models, our TRIAGE tool synthesizes member data (such as diagnoses, claims history, and authorizations) and assigns a risk score to indicate the likelihood of ED visits for Ambulatory Care Sensitive Conditions.

We further assess member utilization through our Member

360°<sup>SM</sup> tool. Member 360°<sup>SM</sup> 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. Member 360°<sup>SM</sup> includes such information as member health risk assessments, care plans, longitudinal member health records, and clinical data. This gives our case managers a whole picture of the member’s needs and the services they receive, allowing us to developed targeted intervention with the member and their providers to promote appropriate service utilization. In addition to data mining, we produce performance reports to identify members with utilization patterns that fall outside the norms. The utilization norms are adjusted to reflect regional and local practice variations and are compared to national benchmarks or Amerigroup aggregate data for all affiliate health plans. Practice and utilization data elements that are included in the analysis appear in Table I.1-3 below.

*Table I.1-3 Mining Data to Identify Under- and Over-Utilization*

Utilization Area	Measurements Evaluated
Acute/Chronic Care	<ul style="list-style-type: none"> <li>• Re-admissions</li> <li>• Pharmaceuticals</li> <li>• Specialty referrals</li> <li>• Emergency Department utilization</li> <li>• Home Health and Durable Medical Equipment (DME) utilization relative to diagnostic entity</li> </ul>
Preventive Care	<ul style="list-style-type: none"> <li>• Well-child/Adult PCP visits</li> <li>• Age-appropriate immunizations</li> <li>• Mammograms</li> <li>• Blood lead testing</li> </ul>

When a member’s utilization pattern shows that outreach and education are warranted, our Nurse Medical Management clinical team will collaborate with the Chief Medical Officer to determine appropriate member interventions, to include outbound telephone calls to educate members about appropriate use of services, the importance of preventive care, or the need to refer to Care Management for care coordination.

### Engaging Members Who Are Difficult to Find

Amerigroup understands that our members’ lives are complicated with barriers and social determinants that affect their ability to deal with their health care. Our goal is to facilitate member access to the services they need by proactively identifying and addressing any issues that may impede the member from actively participating in his or her treatment.

Based on our experience, we know that people who may difficult to find are more likely to attend community events than schedule an appointment with their PCP. Therefore, we collaborate with community- and faith-based organizations to conduct marketing and outreach events to promote health, wellness, and the Amerigroup Louisiana Bayou Health program in the local communities we serve. We share information on the member benefits and services that support member health through wellness, preventative, and specialized services and supports. We also provide individuals with information on how to access preventive care services and the supports available through Amerigroup.

We have established a presence in the community through our feet-on-the-street efforts. We have been successful in using that presence as the foundation for our member education. The relationships and collaborations we have established with our community partners in Louisiana, both public and private, have opened many doors and presented multiple opportunities for member outreach and education.

**Cortana Mall Partnership—Baton Rouge.** In Baton Rouge, we worked with the Cortana Mall to access an empty storefront. This provided us with a neutral location to host outreach and education events, as well as an opportunity to build stronger ties with the community. At the Cortana Mall location, we hosted or partnered with other leading community organizations to host, the following events:

- The Ultimate Baby Shower, in partnership with the March of Dimes, Woman’s Hospital and Family Services of Greater Baton Rouge and Cortana Mall
- Breakfast with Santa in partnership with Cortana Mall
- Town hall and member meetings
- Early Bird Back-to-School, in partnership with Lexlee’s Kids and Cortana Mall
- Provided weekly meeting space for the Big Buddies Program of Baton Rouge

**Homeless Outreach.** We will work with the communities’ connectors to help us locate our members who are homeless, since these connectors will most likely know where the homeless are sheltering themselves and their families. Gathering points can be a shelter, soup kitchen, Walmart, a clinic, a church, or a school event. We will use these venues to reach members who are using these areas as temporary shelter during the day to meet with them and connect them to appropriate housing and health care resources.

Amerigroup will continue to expand our relationships with organizations that serve homeless individuals such as shelters, soup kitchens, and faith-based organizations. For example, *we have sponsored the annual Homeless Awareness Summit organized by the Central Louisiana Homeless Coalition in Alexandria, worked with the Bishop Ott Homeless Shelter in Baton Rouge, and actively participate in coalition meetings with HOPE for the Homeless in Shreveport.* We are actively pursuing relationships with Capital Area Alliance for Homeless and the Acadiana Regional Coalition on Homelessness to further increase our reach.

**Catholic Charities Head Start Program.** We provided sponsorship and work closely with the Catholic Charities Head Start Program, in which *Amerigroup supported 387 students last year at five Head Start locations.* This partnership allowed Amerigroup to strengthen the academic service for Louisiana children; provide items that enhance the fitness program, such as footballs, basketballs and jump ropes; and provide a needed resource for the parents to enhance the students’ health. We have provided resources to attend the Head Start monthly parent meetings; these monthly parent meetings encourage parent participation in school life and stress the vital role that parents play in their children’s lives. By partnering with Head Start, we can engage members and families in health and wellness activities.

**Healthy Start New Orleans.** Amerigroup has partnered with Healthy Start New Orleans, a community-based agency committed to structuring the community through health care, education, and socioeconomic assistance and opportunities that avert negative birth outcomes and promote healthy families and communities. Healthy Start New Orleans is open to residents of the Greater New Orleans parishes who are pregnant or have an infant/toddler under the age of two years. We have supported Healthy Start New Orleans community health events and sponsored nutritional food supplements and appropriate incentive items. Our support has allowed Healthy Starts New Orleans to successfully host many health events that outreach and engage members in the local communities we serve.

**Big Buddy Program of Baton Rouge.** Through this partnership, we promote healthy habits for youth and support the efforts of helping youth through mentoring, extended learning opportunities, and workforce development. The Big Buddy Program has been able to use the storefront at Cortana Mall, which provides a stable place to conduct mentor training, staff training, special parent activities, and group meetings.

**Cervantes Fundación Hispanoamericana de Arte, in the Greater New Orleans area.** For the past two years we have assisted in sponsoring events such as the Que Pasa Fest, which celebrates Hispanic Heritage every October, and Christmas of Hope. These events help raise funds that benefit children. By supporting Cervantes, we have become an important component in its mission, which is to educate the non-Spanish speaking community about the rich art and culture of the Latino people. Through these efforts, we have reduced barriers to care for our Hispanic members and improved the delivery of culturally and linguistically competent services.

**United Way of Northwest Louisiana.** Amerigroup awards Foundation grant dollars to the United Way of Northwest Louisiana to support School Based Health Centers (SBCH) in the Cedar Grove neighborhood in Shreveport, Louisiana. With this help, the United Way was able to serve three centers, 1,700 students, with over 7,000 visits. SBHCs provide a seamless delivery system for health education and services, promoting systemic change. The United Way of Northwest Louisiana works in the forefront with numerous partners, including Amerigroup, in the region to sustain critical programs while expanding services to the underserved populations: communities of color, people with disabilities, people living in poverty, and people with addictive or mental health disorders. *The United Way considers Amerigroup a valuable partner in these efforts.*

**NO/AIDS Task Force.** Amerigroup Louisiana has been a valued partner of this organization during the last several years, assisting clientele with health care needs. When NO/AIDS reached out to the five MCOs after the state discontinued the HIV case management waiver program, *Amerigroup was the only Health plan to respond.* We hosted several meetings to establish a seamless transition for the HIV case management component of their health insurance plan for our clients with Amerigroup.

In addition to partnering with community organizations to outreach and engage members, Amerigroup partners with SafeLink, to provide Bayou Health members with cell phones. Members can receive up to 250 monthly minutes. We augment base services by loading a one-time extra 200 minutes, unlimited nationwide incoming text messages, and free calls to our member services call center. This service provides our case management team and our providers with more consistent and reliable access to members. Members will be able to receive text message reminders about doctor visits and calls from case managers and providers, for example. This improves appointment compliance, adherence to treatment plans, and appropriate follow-up.

SafeLink phones allow our nurse case managers and DM nurses to have real-time, consistent contact with members:

- Reminding members of scheduled appointments
- Scheduling of wellness and checkup appointments for members with special health care needs, such as chronic illness, or members who are pregnant or have a newborn
- Scheduling of preventive services, such as EPSDT, flu shots, and PCP well checks
- Arranging transportation as needed
- Adhering to prescribed medications
- Providing nutritional or weight management tips
- Accessing the nurse case manager contact information

The objectives of the SafeLink program are to improve members' ability to access and engage in the care that is available for their conditions by reducing barriers, resulting in improved outcomes for the members.

## I.2 Coordination of Service Planning and Delivery Upon Discharge

*I.2 For members who need home health and/or other services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital’s discharge planner(s), your case manager(s), your disease management employees member(s), and the home health agency. Further, explain how you will monitor the post-discharge care of enrollees receiving home health services in remote areas.*

### Discharge Planning—Connecting Members to Services and Supports

Amerigroup currently coordinates care for all members in our Louisiana Bayou Health program across the full continuum of care. We have a process in place to coordinate service planning and delivery with the member, family members, caregivers, providers including the home health agencies, and health plan employees. The goal of our discharge planning process is to engage members in services, supports, and resources that minimize the risk of member readmission.

#### Co-located Medical Managers Collaborate with Hospital Discharge Planners

We have learned that the most efficient and effective way to coordinate discharge planning for our members is to co-locate Nurse Medical Management clinicians. This allows us to begin discharge planning with the member, the hospital staff, and their Primary Care Provider on the day of admission. By working side-by-side with

hospital staff and discharge planners, our Nurse Medical Management clinicians have direct knowledge of the treatment provided while the member is inpatient, direct access to the medical team serving the member, and near real-time information from the medical record. Additionally, our staff has the opportunity to regularly meet with the member and family, gaining a deep understanding of the issues that may affect the member’s successful transition to the community. By building close working relationships with facility staff, our Nurse Medical Management clinicians become part of their team, creating an environment of collaboration, which ultimately benefits the member. Our employees participate in discharge planning meetings at the facility, make clinical recommendations for appropriate services upon discharge, conduct authorization reviews, and arrange for the member to receive follow-up services and supports post-discharge.

#### WORKING TOGETHER FOR RESOLUTION

Suffering significant pain from end-stage AIDS, Joseph immediately called his case manager when his pharmacy denied needed pain medication. With his permission, Joseph’s case manager contacted the pharmacy and discovered the prescription had been incorrectly denied. She then contacted the PBM to resolve the issue, but not before Joseph had borrowed the money to pay for his medicine. His case manager contacted the PBM so they could reimburse him and correct the denial to prevent future authorization problems. His case manager let Joseph know his reimbursement was at the pharmacy and that his medicine would be available going forward. Joseph was very grateful for the rapid response from both the case manager and PBM. 

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## Collaborating with Case Managers

Our hospital co-located Nurse Medical Management clinicians contact Amerigroup's case management program upon notification of a member's admission. A case manager with the expertise that is most closely aligned with the member's condition(s) initiates the discharge planning process by contacting the member and, with the member's permission, family members, caregivers, and other natural supports. The case manager also contacts the hospital employees responsible for the member's care and current providers to develop the discharge plan. With the member taking the lead, the discharge plan is jointly developed, identifying the services and supports the member needs to transition to and remain safely in the location of the member's choice.

Through the discharge planning process, we engage the member during face-to-face visits and connect members to their PCP to improve access to follow-up care. Case managers collaborate with the hospital discharge planning staff and extensive member and family support for follow-up appointments, medication reconciliation, wraparound services, member and caregiver education about the specific disease state(s), and coordination of care and services among treating providers, including home- and community-based support coordinators. The goal of our program is to facilitate a smooth transition between inpatient settings and the home or other community setting by providing intensive, short-term support.

To promote member safety and well-being, we contact members telephonically or face-to-face following discharge in the member's home, provider's office, or hospital, depending on the member's risk level, to monitor the member's progress with home-based interventions, facilitate follow up appointments, identify any gaps in care or new challenges to care, and update the care plan as needed.

## Coordinating with Medical Management

As part of the discharge planning process, case managers collaborate with facility staff and the member (and the member's family and/or designee) to select a home health agency that specializes in the member's condition, determine the home health services needed, and identify and eliminate gaps in care and access barriers. For example, for a member with medically complex conditions who is transitioning to home from acute care hospitalization, the case manager verifies that prescriptions are filled and follow-up appointments are scheduled. They identify the member's needs for services and supports, such as durable medical equipment, in-home home health aides or nurses, telemonitoring devices, and non-emergency transportation services, and coordinate with providers to arrange for these services and supports to be in place prior to the transition. Case managers continue to monitor members' progress following the transition and make adjustments in the treatment plan as clinically indicated.

## Supporting Members Through Disease Management Programs

For members with chronic or complex medical conditions, a referral to our Disease Management (DM) program is an important aspect of the discharge plan. Since our goal is to support members in learning to self-manage and take charge of their health care, DM plays an important role in providing them with the information and education they need to stay healthy. Amerigroup's Nurse Medical Management clinicians or case manager assigned to the member will discuss our DM program with the member and his or her family/caregiver, and make the referral for these services. On an on-going basis, our case manager will coordinate with the DM to incorporate all interventions into the member's integrated care plan.

Through our Member 360<sup>SM</sup> application, all staff have access to the member's clinical information and authorizations, fostering communication between departments, reducing duplication of effort, and enabling coordinated service planning. Through these integrated processes and close communication, we can successfully facilitate the effective delivery of medically necessary services in all settings.

## Post-Discharge Care of Members Receiving Home Health Services in Remote Areas

Amerigroup is committed to and adept at developing linkages to service providers and community resources for our members. Our case managers continue to support the member until the member's condition has stabilized and the member is engaged in follow-up care. In our experience, most members need this assistance for 30 to 45 days, although our case managers are available for as long as the member needs. Regardless of whether the member is in an urban or rural location, we provide frequent telephonic contact or face-to-face support to confirm that the member is receiving the post-discharge services on the member's care plan. We tailor the types and frequency of our support based on the member's needs and preferences. Our staff is available to serve members in each of the local communities we serve, no matter how remote.

In addition to the support provided by our case managers, Amerigroup links members in rural and urban areas to on-going support that they can access when they need it. Through the use of technology, members can connect with resources that will assist them in learning to self-manage, empowering the member to take charge of his or her health and wellness. We will offer all members access to online peer support and Amerigroup On Call, connecting them to on-going support post-discharge or whenever they need it.

Through the use of technology, members can connect with resources that will assist them in learning to self-manage, empowering the member to take charge of their health and wellness. 🌿

**Online Peer Support.** Amerigroup will enable members *increased personal responsibility and self-management* by providing an online peer support tool to help members manage their chronic conditions. Amerigroup will partner with an external vendor specializing in the development of social networking tools to provide members with virtual peer support. This innovative program is a social networking platform that connects members to peer support and behavior change professionals for help in managing chronic and behavioral health conditions. Members may participate in group chat, online meetings, and expert discussions. The program leverages gaming and online social networking techniques to build online peer support communities and behavioral modification programs. Programs treat a range of substance use disorders and behavioral conditions, including depression, anxiety, eating disorders, gambling, smoking cessation, and obesity. Delivered through a secure, HIPAA-compliant online and mobile platform, the program will provide members access to integrated, condition-specific social health communities that offer emotional check-ins, evidence-based tools, and game mechanics to help them manage their own care and sustain positive behavior change.

*Confidential, proprietary, and/or trade secret language has been redacted from this page. Please refer to our proposal binders marked "Original" to access a non-redacted version of our response.*

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We will also provide members in rural areas with post-discharge care via telemedicine. Available through our partnerships with FQHCs, CMHCs, RHCs, and other provider organizations, we will promote the use of telemedicine to improve member participation in follow-up care.

By giving members, providers, and care coordinators easy access to programs and services available in the community, we will **improve coordination of care** and support **better health outcomes**. As members are accessing this information for their own needs, we are helping them to increase their **personal responsibility and self-management**.

## I.3 Specialty Care Access in Rural Areas

***I.3 Aside from transportation, what specific measures will you take to ensure that members in rural parishes, or other areas where access is an issue, are able to access specialty care? Describe any plans for using telemedicine to expand services. Also address specifically how will you ensure members with disabilities have access?***

Amerigroup recognizes that access to specialty care is limited in several areas in Louisiana, particularly in rural parishes. Together with our affiliate health plans in numerous rural markets across the nation, we leverage and employ an array of proven strategies, such as described below, that improve access.

- Monitoring of our current provider network through GeoAccess<sup>®</sup> to identify network gaps in access and inform provider network development efforts
- On-going partnering with strong network providers to open offices in rural areas, offer additional needed services, and provide after hours and weekend appointments
- Co-locating of clinical health plan and provider staff in FQHCs, CMHCs, RHCs, and School-based Health Clinics (SBHCs)
- Developing innovative programs that provide supportive, in-home case management and identify available community-based resources, such as our Nurse and Family Partnership for at-risk pregnant women and mothers
- Creating awareness and use of existing telemedicine opportunities, as well as identifying and funding additional opportunities through partnerships with providers and community-based organizations
- Contracting with Alere to provide in-home and telephonic pregnancy monitoring for members with high-risk pregnancies through home injections, hyperemesis treatment, and pre-term labor management
- Providing a prenatal packet to all pregnant members upon identification that provides important information to support healthy mom choices, including early and on-going prenatal care, nutrition, and choosing a pediatrician prior to childbirth

***We continue to collaborate with the Louisiana Rural Health Association and the Louisiana Rural Health Coalition to identify and assess opportunities for boosting access to specialty services throughout Louisiana's rural parishes.*** Amerigroup also synchronizes its efforts with DHH's Bureau of Primary Care and Rural Health to make sure we build upon and do not duplicate existing initiatives within the State.

Our strategies for increasing access to care in rural and hard-to-reach areas include expanding the use of technology in rural areas, contracting with community health centers, and authorizing services provided by out-of-network providers. We will also implement targeted strategies for connecting members with developmental disabilities to services, such as specific outreach events, and educational programs directed toward informing members with disabilities, their caregivers, and providers about how to access available services.

## Enabling Tele- and Electronic-Consultations

Amerigroup will leverage the latest technology to connect members to the care they need. 

Amerigroup will continuously work to increase member access to services and supports in rural areas. We will leverage the latest technology to connect members to care they need, including our innovative Amerigroup On Call program and through increased use of telemedicine services.

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## Using Telemedicine to Increase Member Access

Telemedicine enables members to receive the care they need in a timely fashion, regardless of their geographic barriers to access. Amerigroup will increase member access to care through the use of telemedicine in rural areas. Available through our partnerships with FQHCs, CMHCs, and RHCs, and other provider organizations, we will promote the use of telemedicine to improve member participation in follow-up care.

## Enhancing Services Available Through FQHCs, CMHCs, RHCs and SBHCs

Amerigroup cultivates deep roots in the communities we serve, and we seek long-term solutions to health care challenges, including the lack of access to specialty care in rural areas as reflected in the letter of support below from Primary Health Services in Monroe. A strategy that has been effective in other states is collaboration with FQHCs, CMHCs, RHCs, and SBHCs to expand their scope of specialty services. These providers have established operations in rural communities, including relationships with recipients, community agencies, and other stakeholders.

In other states, we have worked with FQHCs and RHCs to add specialty services not currently available locally. For example, in one area, access to behavioral health services was restricted, so Amerigroup our affiliate? worked with the local primary care providers to add a behavioral health specialist to the practice, enabling access to specialty services that had been severely limited, to improve health outcomes in the community. Amerigroup actively explores similar options for other specialty services that can be built into the existing infrastructure of rural Louisiana safety net providers.

## Authorizing Access to Out-of-Network Providers

Additionally, throughout the care management process, we monitor access to care and collaborate with our network development team should we identify trends that suggest restricted access in parts of the state. In all cases, we focus on facilitating member access to the full array of services available to them. When an in-network provider is not available to meet a member's non-emergency needs, Amerigroup refers the member to an out-of-network provider. In this instance, the Nurse Medical Management clinician or nurse case manager monitors the case from the point of a request for an out-of-network authorization, verifying that treatment is available and delivered.

Upon receipt of an authorization request from the PCP, our medical management clinician verifies member eligibility and then ascertains the reason the service is requested of an out-of-network practitioner or facility. The Nurse Medical Management clinician performing the assessment of the member's health needs forwards cases requiring continuity of care coordination to our Chief Medical Officer or Behavioral

### WORKING TOGETHER IN RURAL LOUISIANA

**The Benoit family, who lived in a very rural area, was new to Amerigroup Louisiana. During new member outreach, we discovered the father, Robert, had spent two weeks searching for a pediatrician within a reasonable driving distance. Our case manager worked with Robert to find a local pediatrician, then scheduled an initial appointment for the children to be seen within the week. She also requested that their previous pediatrician send health records to their new provider. Robert went from being unhappy to saying he really appreciated our help.** 

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Health Medical Director for further discussion and review determination. If the Chief Medical Officer deems providing services by the out-of-network practitioner is medically necessary, we take the following actions:

- We check to verify provider licensure and no licensure sanctions, including confirmation that the provider does not appear on any exclusion lists, at a minimum, when we authorize care to an out-of-network provider. We will not enter into single case agreements with any provider who has sanctions.
- Our medical management department approves the authorization for services by an out-of-network provider.
- Our provider relations department negotiates a single-case agreement with the provider which sets forth provider payment (a comparable in-state/network rate, the State Medicaid FFS rate, State-approved out-of-network provider payment methodology, or a negotiated fee schedule) as well as prior authorization and care management requirements.
- During its initial contact with an out-of-network provider, our provider relations department develops a relationship with the provider to encourage contracting with Amerigroup and to establish open, two-way communication to support information sharing and coordination of care.
- Our medical management department develops a strategy to coordinate a member's transition to an in-plan provider once the member is stable or the care requires long-term treatment that is available from a participating practitioner.

## Access for Members with Disabilities

In our experience of serving members with developmental disabilities in Louisiana and across the country, we know that these members are at risk for extended inpatient stay. This is due, in part, to the lack of providers with the expertise to meet their complex needs. Amerigroup takes a multi-faceted approach to improving access to care for members with disabilities, which includes identifying providers who work with members with disabilities; working with advocacy organizations, members, system partners, and families to identify additional providers; and monitoring access to care.

### Identifying In-Network Providers

During the credentialing and contracting processes, we ask our providers to identify any special licensing or services offered so that we understand the range of providers who are capable of meeting the needs of our members with specialized service needs. Providers may have specially trained staff; accessible Durable Medical Equipment (DME), such as wheelchair-accessible dental chairs and lift-able exam tables; mammography; or other unique capabilities to serve members with specialized health care needs. We train health plan staff on these and capture and make this information readily accessible to our member services representatives and case managers to identify the providers who best meet the individual needs of the member.

### Connecting with Providers Through Community Partnerships

Providers (such as HCBS waiver Providers), members and families/caregivers, system partners, community-based organizations, and advocacy groups have an important role in delivering services to persons with disabilities. They not only provide valuable services and supports to the member, but they also offer first-hand knowledge of the issues that affect the member's health and well-being, such as comorbidities and individual beliefs, values, and preferences. Additionally, these stakeholders are well aware of the providers who work best with members with disabilities, some of whom may not be in the Amerigroup network.

Amerigroup has established a Member Advisory Committee (MAC) that is composed of members, family members, caregivers, relevant advocacy groups, and community partners. The MAC provides, among an array of guidance, input on providers and provider offices to make sure that we tap into the knowledge and history that stakeholders and consumers have within the State. We engage those stakeholders and providers who have been working with our members and their families, identify specialized services (DME, language interpreters), and understand our members and their preferences to ensure the accessibility and relevance of our service delivery system. These stakeholders also refer us to providers who may be willing to join our network, or enter into a single-case agreement to serve members with disabilities. Our Provider Network representatives contact these providers to establish a relationship and discuss joining our network. In this way, we can target our network expansion efforts toward those providers that are experienced and skilled in meeting members' needs.

### Monitoring Network Adequacy

Amerigroup routinely monitors network adequacy to confirm that services are available and accessible to members with disabilities, and delivered by providers with the appropriate expertise. To facilitate access to health care services for all members, including those with disabilities, we measure and verify access to care, including the following:

- Quarterly assessment of the network access with respect to State standards
- Review of GeoAccess reports, out-of-network provider single-case agreement listings, and medical and case management referrals to determine any network gaps
- On-going monitoring of network access, appointment availability, and provider compliance with after-hours coverage through surveys and member complaints
- Verifying that our providers meet or exceed ADA requirements as required in the provider contract and capturing and tracking the information in our management system

***We generate and review GeoAccess reports for members who are identified as having special needs and compare this to our provider network capabilities.*** We also generate and review GeoAccess reports on access to our special services, including physical therapists, occupational therapists, speech therapists, DME providers, and audiologists.

Additionally, as part of the initial credentialing of PCPs, obstetricians, and gynecologists, an Amerigroup representative completes an on-site visit to determine compliance with standards for physical accessibility, physical appearance of the office environment, adequacy of waiting and examining rooms, adequacy of medical recordkeeping practices, appointment availability, and office operations. This site review includes verifying, at a minimum, that these providers have the appropriate-height examining tables for members with disabilities and that they meet all the requirements for accessible services.

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