Amerigroup Case Management and Coordinated Care Best Practices

Issue Defined

“Dual eligibles” is a term used to define individuals who receive health insurance coverage under both Medicare and Medicaid. According to the Kaiser Family Foundation, many dual eligibles are under the age of 65, have disabilities and are financially vulnerable. Dual eligibles have disproportionately more chronic, disabling and complex health conditions than other individuals enrolled in Medicare or Medicaid. Typically, they use a wide range of costly services and draw coverage from both Medicare and Medicaid. Because these two programs cover two different types of services – acute and long-term care, respectively – ensuring coordination and continuity of care and services historically has been a challenge in serving the dual eligible population. Many states have turned to managed care as a means of streamlining care through individualized and targeted care coordination practices.

Solution and Strategy

Our integrated care and service coordination services are designed to address the chronic health care needs of dual eligible beneficiaries receiving care from both Medicare and Medicaid. We go beyond a medical case management model to address the long-term services and supports necessary to the well-being of dual eligibles.

Our Medicare Advantage plans deliver cost-effective coordinated care to produce positive health outcomes for our members. We succeed in promoting coordination of care across Medicare, Medicaid, Home- and Community-Based Services (HCBS), and social services by:

- Identifying and prioritizing members who will benefit the most from service coordination
- Calibrating the intensity of service coordination to each individual’s specific needs
- Engaging members in a personalized service plan, thereby improving health status and encouraging adherence to healthful practices
- Streamlining member health data through the use of field-based screenings
- Integrating disease management and service coordination programs through joint complex rounds
- Eliminating gaps in care by promoting provider engagement through primary care and physician outreach
- Emphasizing prevention and primary care through member outreach and education

Identifying and Prioritizing Members

The cornerstone of our care coordination program results from leveraging technology and data to identify our highest risk members. Using predictive modeling tools, we synthesize member data such as diagnoses, hospitalizations, emergency room encounters, expenditures and demographics to develop individualized risk profiles. Members are assigned a chronic illness intensity index score based on these factors. Once scored, members are filtered through clinical criteria that prioritize individuals with clinically manageable conditions. The resulting list represents those members with the most acute and complex illness burden.

Additionally, Amerigroup identifies those members for whom we need to coordinate care with an external entity – that is, members with specialized behavioral health issues or members receiving targeted case management. By identifying these individuals up front, we can reach out to those external entities and begin planning collaboration efforts for each member.

Augmenting the predictive modeling tools, referrals for service coordination can originate from a number of sources, including outreach by health plan staff, member services through the new-member welcome call, disease management associates, pharmacy associates, other members, providers, community-based organizations and state or local government agencies.
**Engaging Members in Care**

Once high-risk members have been identified, they are contacted by a service coordinator. Rather than enroll members in separate care coordination programs based on their specific conditions (such as, separate plans for managing diabetes and depression for a member who is diagnosed with both conditions), our integrated program reflects accountability for coordinating care for each member. Once the members are enrolled in a program (disease management or case management), their service coordinator assumes responsibility for coordinating all necessary care across the spectrum of services.

Service coordinators engage members in managing their own conditions by first assessing each individual’s willingness to participate in a service plan. The Patient Activation Measure tool is used to quantify members’ knowledge and confidence in managing their own health. This allows Amerigroup to build on the individual’s existing strengths and coach the member to greater levels of engagement.

Service coordinators prepare personalized service plans, which coordinate all services from caregivers and providers and are aimed at reaching treatment goals and avoiding barriers to care. These plans may include telephonic and field-based outreach delivered by a multidisciplinary team to ensure all needs are addressed.

**Streamlining Care and Tracking Patient Progress**

Amerigroup service coordinators use enhanced clinical support tools such as CareCompass and our iPad-based CareCompass Mobile application to reduce unnecessary administrative burden, thereby allowing them to spend more face-to-face time with members. CareCompass stores members’ clinical information, including medical lab and ancillary services information, which provides the entire clinical team with a full picture of all care and services furnished for each member. The program is being piloted in our Amerigroup Texas plan. Assessment details are aggregated with other clinical information and members’ historical utilization data to give the case managers the information needed to efficiently coordinate services.

**Integrating Programs Through Joint Complex Rounds**

Further supporting coordination of care, joint complex rounds are held at least weekly in each of our health plans. An interdisciplinary staff collectively meets to review and update individual care plans and gather collaborative input from multidisciplinary team members to enhance the care plan. Complex case rounds are led by the plan medical director and include experts in medical, behavioral health and social support areas.

**Promoting Primary Care and Physician Outreach**

Our service coordination program reinforces the importance of primary care as the member’s medical home, and the Primary Care Physician (PCP) is actively engaged in the service coordination process through ongoing monitoring, telephone calls and periodic written updates to the member’s service plan. PCPs receive by mail or fax a copy of the service plan and relevant clinical practice guidelines. Our service coordination team respects the role of the PCP and, for members whose care may not be progressing, our medical director may initiate more in-depth conversations to strategize potential solutions.

**Emphasizing Prevention**

With inpatient census information (including emergency room use), we reach out to initiate discharge planning for members who are hospitalized or visit the emergency room, coordinating all follow-up services, such as home care, that may be necessary to facilitate a smooth transition from an inpatient to a home setting. By following up on hospitalizations, we ensure continuity of care and help prevent future nonemergent use of hospital emergency departments.

**Outcomes and Savings**

Our Medicare Advantage plans in Texas and New Mexico serve dual eligibles participating in Medicare Advantage integrated care programs. The Texas STAR+PLUS program is estimated to serve 214,328 of the state’s dual eligibles in 2013. This integrated model is mandatory for Medicaid enrollees who are 21 years of age or older. To date in 2013, Amerigroup serves over 130,000 Texas STAR+PLUS beneficiaries.

In New Mexico, the state’s Coordination of Long-Term Services (CoLTS) program reduces institutionalization and avoidable episodes of acute care for 37,353 mandatorily enrolled Medicaid enrollees, 31,580 of whom are dual eligibles. The CoLTS program combines standard Medicaid acute care services and optional medical services the state has chosen to cover along with long-term services and supports.
Overall, our plans deliver cost-effective, coordinated care through Medicaid and Medicare by directly working with members to identify specific needs and interfacing with their providers to facilitate patient care. The following are some highlights of our programs in Texas and New Mexico:

- 88 percent of members 45 to 64 years old and 87 percent of members 65 years and older had an outpatient or preventive care visit during the measurement period. For each of these age groups, the STAR+PLUS program had higher rates of preventive care visits than what Medicaid managed care plans reported nationally.

- Ninety-four percent of STAR+PLUS members 10 to 17 years old and 91 percent of members 18 to 56 years old were appropriately treated for asthma. This exceeded the Health and Human Services Commission Quality Dashboard standards of 57 percent (10 to 17 year olds) and 62 percent (18 to 56 year olds).

- The majority of STAR+PLUS members provided high ratings of their health care, doctors and Managed Care Organizations, indicated by a rating of 9 or 10 on a 10-point scale. These ratings were comparable to those published from Medicaid national data.

- The New Mexico CoLTS program has reintegrated 207 members from nursing facilities into the community and has kept 2,345 healthy dual eligibles out of nursing facility placement.

- In State Fiscal Year 2009, with the launch of CoLTS, the cost Per Member Per Month (PMPM) was $1,760; this compares to an estimated PMPM cost of $1,812 if CoLTS had not been implemented.
3. Ameigroup membership data (March 2013).
5. 2010 STAR+PLUS Quality of Care Report
6. Ibid
7. SFY 2011 STAR+PLUS Adult Member Survey