Amerigroup Long Term Services and Supports (LTSS) Case Management/Care Coordination
Case Management/Care Coordination

Case Manager is responsible for Care Coordination

SMMC – LTC Services

State Service Providers

Community Resources

Caregiver

PCP & Medical Services

Behavioral Health

Nursing Facility

ALF/AFCH

Hospice

SMMC – LTC Enrollee

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Amerigroup’s Long Term Services and Supports (LTSS) Program

The Amerigroup’s LTSS Service Coordination Model was adopted to assist enrollees in gaining access to needed long term care services and integration to care delivery through ongoing assessment and monitoring.

The LTSS Model assigns an Amerigroup LTSS Coordinator as the Enrollee’s Case Manager (assigned immediately upon enrollment and make initial face-to-face contact within 5 business days for Home and Community-based enrollees).
Assessment, Care Planning, and Service Monitoring
Assessment

• Case Manager assignment is based on review of state data, identification of high risk enrollees and facility placement, and consideration of Case Manager’s specialized expertise

• Case Manager meets face to face with the enrollee (within 5 business days of the enrollment month), representative, caregiver, and/or the enrollee’s chosen support person at the initial contact. A telephonic follow-up with the enrollee within 7 business days after initial contact. At minimum, a monthly telephonic contact to verify satisfaction and receipt of services. A face to face review of the enrollee and their care plan every 90 days, or sooner, if necessary. An annual face to face reassessment review to determine ongoing functional status and care plan review.
  – Uses the Enrollee Handbook and Provider Directory
  – Uses the most recently completed 701B assessment
  – Review of current medications and enrollee’s ability to safely manage
  – Uses the enrollees most current care plan
  – Use of tablet technology to identify and document needs in real time while in the enrollee’s place of residence
  – Annually an Amerigroup Universal Assessment Tool (UAT) is completed
    • Maps to the 701B assessment form
Assessment

• Face to Face Visits can be done out of cycle
  – Enrollee has had a significant change
  – Enrollee has had an inpatient admission
  – Enrollee requests a visit to discuss services or care coordination face to face

• Enrollees with high risk needs, medically complex needs, or enrollees assessed as having pharmacological issues are staffed with our multi-disciplinary team, including our Geriatric Medical Director.
Care Planning

Together the enrollee, representative, caregiver, and/or the enrollee’s chosen support person and the Case Manager develop a care plan or Community Living Support Plan (for ALF enrollees)

• Addresses the enrollee’s functional needs
• Identifies and addresses risk factors, barriers to progress and the interventions established to achieve the desired goals
• Establishes the enrollee’s measurable personal goals
• Identifies the enrollee’s individualized service schedule
• Promotes coordination of formal physical, environmental, functional, behavioral and social services
• Establishes medication management strategies and identifies pharmacological issues
• Allows for coordination of acute care services
• Allows assessment of the current placement setting and if it is meeting the enrollee’s needs
Service Monitoring

**Monthly contact:** care plan review, identify significant changes, verify receipt of services, verify satisfaction of services and providers

**Face to Face visits:** conduct a quarterly assessment, care plan review, identify significant changes, verify receipt of services, verify satisfaction of services and providers

**Annual reassessment:** complete a comprehensive assessment (701B), care plan review, identify significant changes, verify receipt of services, verify satisfaction of services and providers
ALF Enrollees with Behavioral Health Needs
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- Case Manager identifies the enrollee has a behavioral health diagnosis upon the orientation assessment (within 5 business days of enrollment)
- If enrollee resides in an ALF, CM will discuss the enrollee’s behavior health needs with the enrollee and family and the ALF Operator
- As part of the orientation assessment, the Case Manager discusses the needs of the member with the ALF Operator or designee
- Depending upon the member needs, CM will involve appropriate ALF staff to assure member needs are able to be met by ALF
- Case Manager will assist in the coordination of obtaining behavioral health services outside the ALF if required
  - Adult day health programs
  - Behavioral Health centers for outpatient group and/or individual therapy (CMHC’s)
  - Communication with BH inpatient facilities as needed
ALF Enrollees with Behavioral Health Needs

• A Case manager may identify an enrollee who is in need of an ALF with a Limited Mental Health License, the Case Manager will lead the coordination of finding an appropriate facility by:
  – reviewing/staffing the enrollee’s diagnosis and needs with the Medical Director
  – researching which AGP participating ALFs have a behavioral health license on the AHCA Florida Health Finder website
  – contacting the ALF to provide information about the member to ensure the facility is appropriate for the enrollee’s needs

*Note: This is done continually through the member’s enrollment
Coordination of Care between BH Members and the PCP

- As needed, Amerigroup’s Medical Director will reach out to the member’s PCP to gather any insight which allows us to take better care of the member.
- The CM will coordinate and communicate the Medical Director and PCP’s recommendations with the ALF.
- The flow of communication between all parties is ongoing based on the member needs.