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Amerigroup Community Care implementation provider transition
Frequently asked questions (FAQ)

Background:
Amerigroup Community Care was awarded a new contract as a Medicaid managed care organization (MCO) for the State of Tennessee. This new contract begins January 1, 2015, and includes the East, Middle and West regions. Amerigroup has been a Medicaid MCO in Tennessee since 2007 in the Grand Middle region and is committed to ensuring continuity of care and no disruption to services during this transition for the reassigned members.

1. **When will the membership in East and West Tennessee become effective with Amerigroup?**
   Members will become effective with Amerigroup in the East and West regions on January 1, 2015. Additional CHOICES long-term services and supports (LTSS) members will join Amerigroup on April 1, 2015.

2. **Why are members in East and West Tennessee being transitioned to Amerigroup?**
   The State of Tennessee, Department of Finance and Administration and the Bureau of TennCare issued a statewide request for proposal to offer more options to Medicaid members in Tennessee. Currently there are two health plans in each region. Beginning January 1, 2015, there will be three TennCare health plans in each region.

3. **How many members will be transitioned to Amerigroup?**
   There will be approximately 240,000 members in East and West Tennessee who will be transitioned to Amerigroup effective at 12:01 a.m. on January 1, 2015.

4. **How will TennCare communicate these changes to members?**
   On November 14, 2014, TennCare sent a letter to all members notifying them of their assignment to Amerigroup. Amerigroup sent all new members a welcome letter on November 21, 2014. Beginning in December, members will receive their ID cards.

5. **Will members have an opportunity to select another MCO?**
   Members will have until February 14, 2015, to tell TennCare that they would like to stay with their current MCO versus the new assigned MCO.

6. **If the member decides to stay with their current MCO, can others in the family still change?**
   No; all members of the household who are on TennCare must have coverage with the same MCO. The only exception is if other household members are in TennCareSelect.

7. **When will ID cards be issued to members transitioning to Amerigroup?**
   East and West Tennessee members transitioning to Amerigroup will be mailed ID cards beginning in December 2014. Members should allow 10 to 14 days to receive new ID cards. Providers may access the state's eligibility verification system at to verify the member's MCO.

   Note: Members will be assigned a PCP; however, they may call to request a change.

8. **If a provider is not contracted with Amerigroup, will they be given an opportunity to do so?**
   To inquire about contracting with Amerigroup, visit providers.amerigroup.com/TN and select Join Our Network. You will be contacted by a Provider Relations representative regarding next steps.

9. **How will members who are currently on an existing course of treatment (physical health/behavioral health or obstetrics) be transitioned?**
   Members will be able to continue to receive services from their treating provider for up to 30 days, except in certain situations (e.g., a pregnant woman in her second or third trimester will be able to keep her current health care provider through her delivery and follow-up care even if her provider is not a participating provider with Amerigroup). Amerigroup will coordinate care for any member during and after the transition.

10. **What fee schedule will providers be paid during the 30 days they can continue to see the members?**
    Participating providers will be paid in accordance with their contract and nonparticipating providers will be paid 80 percent of the Amerigroup fee schedule.

11. **Will I keep my current assigned members?**
    Amerigroup will receive PCP assignment information from the previous MCOs. To reduce disruption due to transition, we will attempt to assign members to their existing PCP, when possible. Members can call Amerigroup Member Services at 1-800-600-4441 and select their PCP from the MCO they are transitioning from if the PCP is in the Amerigroup network.

12. **What will happen to a member's prescription refills?**
    The TennCare pharmacy benefit will not change. TennCare, not Amerigroup, will pay for prescriptions. For members with TennCare and Medicare, Medicare Part D is responsible for their prescriptions. Throughout the transition and after, transitioning members will be able to access pharmacy services as they have in the past.

13. **What services require authorization by Amerigroup?**
    Please see providers.amerigroup.com/pages/pluto.aspx for a list of the services that require authorization.

14. **What will happen to a member's prior authorization that was issued by the MCO which the member is transitioning from?**

    To ensure continuity of ongoing treatment and services, the current MCO is transferring this information to Amerigroup. Members and/or providers can call Amerigroup if they need help. If a provider has obtained an authorization or a referral from another MCO prior to January 1, 2015 for the member to obtain care that has not started, the provider should contact Amerigroup to obtain any necessary authorizations for the service. Amerigroup will be responsible for providing all new prior authorizations after January 1, 2015.

15. **How do I handle an inpatient admission for a member that was admitted under the previous MCO and discharged under Amerigroup?**

    Amerigroup will continue to provide medically necessary covered services for transitioned members. Providers need to contact Amerigroup to obtain an authorization for continued inpatient services as early as January 2, 2015, but before the expiration date of the initial authorization.

16. **Claim billing guidelines**

    - For members admitted to inpatient stays at the time they are transitioned to another MCO, the hospital will be reimbursed based on a DRG or the provider agreement, whichever is determined to be most cost effective.
    - The hospital should not file a split bill to each MCO. The hospital should file the entire bill to both MCOs.
    - The MCOs will divide the DRG reimbursement amount by the number of inpatient days for the entire stay and determine a per day rate. Reimbursement should equal the per day rate multiplied by the number of inpatient days that the member's inpatient stay fell within the enrollment responsibility of the MCO.
    - The previous MCO will be responsible for the days prior to January 1, 2015, and payment will be based on their provider agreements.
    - The MCOs will work together in the event there are concerns surrounding the payment of a facility claim that spans past January 1, 2015.

      Example:

        - Member is effective with the new MCO on January 1, 2015
        - Claim dates of service in field 6 of the facility claim form is December 30, 2014 through January 1, 2015, Service Units in field 46 is 6
        - Divide DRG Payment by 6 to come up with a per date rate
        - Original MCO would pay per day rate for 2 days (December 30, 2014 and December 31, 2014)

17. **What are the contact numbers for Amerigroup?**

    - Provider Services: 1-800-454-3730
    - Member Services: 1-800-600-4441