Ready, Set, Go! The Readiness Review Process for Care Coordination and Provider Network Adequacy in Minnesota

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This case study summary is based on the opinions expressed by state officials during interviews and email exchanges between 2012 and 2013. It does not reflect AARP policy or opinion.

Overview
Since 1997, the Minnesota Department of Human Services (MDHS) has operated Minnesota Senior Health Options (MSHO), a voluntary program that combines Medicare and Medicaid financing. MSHO provides managed primary, acute, and managed long-term services and supports (LTSS), including 180 days of nursing facility care, home- and community-based services (HCBS), behavioral health services, and prescription drugs. To be eligible for MSHO, individuals must be Medicare beneficiaries who are aged 65 and older and who are also enrolled in Medicaid (e.g., dual eligibles). The MDHS contracts with eight managed care organizations (MCOs) to provide MSHO services to approximately 36,000 dual eligibles across the state. According to one state official, all of the contracted MCOs are locally developed, not-for-profit MCOs that “share the same values and ethics as the state officials who oversee them.”

The state has not added any new MCOs since 2005, when six MCOs were added to the program. Therefore, what follows describes what state officials did prior to that date to ensure that the newly added MCOs were prepared to provide care coordination and that their LTSS provider networks were adequate. The MDHS has primary responsibility for assessing MCO readiness, and it conducts both a desk and onsite review to accomplish this goal. The template for the desk review follows the contract procurement requirements in the state’s request for proposals.

Readiness to Provide Care Coordination Services

The MDHS used desk review to ensure that MCOs were prepared to provide care coordination services before they begin enrollment. During desk review, MCOs were required to provide documents that demonstrate how they train care coordinators to meet all state and MCO requirements. Care coordinators must be licensed registered nurses, licensed social workers, or licensed nurse practitioners. The state also requires them to be certified Minnesota assessors (CMAs). A CMA is a person who successfully completes state-sponsored training about how to conduct assessments of consumers who will receive LTSS. Individuals seeking CMA certification must have 12 full months of experience conducting
assessments that determine eligibility for receipt of LTSS.

State officials also expected MCOs to have protocols for care coordinators to follow, and they worked with the MCOs to develop the protocols. According to one state official: “If you [the MCO] have trained care coordinators and you [the MCO] have protocols in place, things should go smoothly.”

Because of the licensure requirement, the required 1 year of experience, and the CMA certification requirement, state officials felt confident the MCOs are using well-trained, high-caliber care coordinators. State officials indicated that although the MCOs had primary responsibility for training care coordinators, the state provided supplemental training by conducting web-based video conferences (offered by the State Department on Aging) about topics relevant to care coordination. Examples included the following: level of care criteria; care transitions; HCBS waiver policy changes; person-centered care planning; how to submit LTSS assessment documents; and the Money Follows the Person Rebalancing Demonstration Grant Program.  

State officials conducted a series of conversations with MCO representatives to gain an understanding of the MCO’s approach to development of care coordination networks and whether the MCOs took a top-down or bottom-up approach to care coordination. Favoring a bottom-up approach, one state official said: “We think that care coordinators need freedom and flexibility to service the needs of the client, rather than be constrained by too many administrative requirements imposed on them by the MCOs.”

State officials convened ongoing stakeholder groups to help them oversee MCO performance. They noted that although anyone could be a part of these groups, they were typically attended by (a) consumers; (b) providers; (c) county representatives; (d) consumer advocates; (e) union representatives; (f) legal aid attorneys; and (g) representatives from care management agencies. During these meetings, which were attended by as many as 200 individuals, MCO representatives gave presentations related to care coordination, and stakeholders were given the opportunity to ask questions about the care coordination processes. However, one state official said: “When we undertake a readiness review process, we ask for volunteers from the larger stakeholder group to participate in interviewing MCOs as part of that process.”

State officials in Minnesota said their contracted MCOs played a major role in care coordinator training. However, state officials also stressed the importance of state-sponsored supplemental training. Minnesota officials said they did this by sponsoring (and funding) statewide video conferences that address aspects of care coordination. In addition, the state sponsored an annual community-based services conference at which care coordination topics are addressed. The MCOs typically paid a fee for care coordinators and/or their managers to attend the conference.

**Determination of LTSS Provider Network Adequacy**

The network adequacy component of the readiness review process in Minnesota is primarily a desk-based activity. The MCOs are required to submit detailed descriptions of their provider networks to the MDHS. The MDHS reviews and approves MCO provider networks to ensure compliance with state licensing criteria and with the MDHS criteria related to scope, geographic access, cultural competence, and language.
adequacy. MCOs must also submit HCBS provider network lists to the MDHS annually and keep these lists updated in provider directories.

To determine HCBS provider network adequacy, the MDHS uses a “generally accepted community standard,” meaning they require access to services through MCOs be equal to or greater than that available in a fee-for-service (FFS) system for metropolitan and nonmetropolitan areas. Because the state has large rural areas that may have a limited number of LTSS providers, MDHS does not set numeric criteria for HCBS providers. Instead, state officials expect MCOs to use the HCBS providers that are available in the FFS system. According to one state official: “This could mean that there is a shortage of a certain provider type for everyone, including people in FFS and in the health MCOs.” In these cases, the MCOs are required to find creative ways to meet the needs of consumers. Their efforts are supported by other state agencies; for example, MDHS partners with the MCOs to conduct a gap analysis to determine whether the numbers of LTSS providers are adequate.

The state also contracts with Area Agencies on Aging (AAA), operating under Eldercare Development Partnerships, to develop new providers where gaps are found. The AAA staff work with LTSS providers to get them to add new services to their offerings if they identify a need for a particular LTSS service in an area. If the provider is willing to expand its service offerings to meet a particular need, AAA staff help the provider develop a business plan for adding the new service to its portfolio, and then help the provider connect with other entities in the community that can support their expansion efforts. The AAA staff also help LTSS service providers increase their use of volunteer sources of service delivery (e.g., for services such as chores, cutting grass, shoveling snow, and delivering meals) by helping them identify cost-effective ways to recruit and train volunteers. Finally, the AAA staff support the development of LTSS providers by helping small LTSS service providers identify ways they can achieve economies of scale. For example, AAA staff might identify several service providers in an area that are providing the same set of services. The AAA staff will work with these providers to determine whether they can consolidate some administrative functions, such as billing.

Before the state began implementing managed LTSS, counties within the state developed their own provider networks to deliver HCBS to consumers. When the state began implementing managed LTSS using MCOs, in many instances, the MCOs contracted directly with counties to implement and oversee the HCBS portion of their contracts with the state. In metropolitan areas, where there are many provider options, MCOs tend to be more selective when contracting for home health, personal care, and assisted living services; they may implement additional participation criteria based on quality standards and experience.

Although MCOs generally contract with most nursing facilities in their area, they are not required to do so because MDHS requires MCOs to pay the state’s Medicaid nursing facility rate whether or not they have contracts with those facilities. The state is currently transitioning from a county-based to a centralized system for reviewing, approving, and contracting with HCBS providers. Under the new system, MCOs can continue to contract directly with LTSS providers or they can use an open network in which they accept any state-approved provider. MCOs may use providers that do not participate in the state’s network—as long as those providers meet all required standards.
The MCOs must demonstrate to the state that they have sufficient processes for ongoing provider oversight, including mechanisms for verifying that HCBS waiver providers meet required standards. The MDHS monitors this requirement during onsite visits and issues a corrective action order if it is found that the community network does not compare to the available providers used in a FFS system in that service area. A corrective action order can also be issued if the MCO’s processes for ongoing monitoring of network adequacy are insufficient.

Advice from State Officials

“Be careful what you ask for in a readiness review,” one state official advised. “For the system to be able to mature, you need to allow for flexibility.” State officials stressed that managed LTSS programs begin with a set of contract requirements that are improved upon over time through a mutual learning process between the state and the MCOs. For example, the state has clarified and improved its care coordination contract requirements over time as improved practices are identified.

State officials stressed the importance of making sure large commercial MCOs do not lose their focus on the LTSS side of the business. They said that this can easily happen with MCOs that have traditionally provided managed acute and primary care. They also said it is important for large MCOs that are new to either Medicare or Medicaid to make sure their staff receive training in the differences between the programs. This is important, they said, because both programs may pay for the same service but have different criteria for receipt of the service.

Officials highlighted the importance of states staying engaged in ongoing care coordinator training to ensure consistency among MCOs, and to ensure care coordinators are kept informed of changes in a state’s managed LTSS program’s goals and policies. They also stressed the importance of closely monitoring MCO performance. According to one state official: “In the beginning, you have to have daily contact with each plan’s [MCO’s] key staff. We used site visits a lot at first during those early days.”

State officials also stressed the importance of looking at how the system of care impacts beneficiaries to determine whether, as one official said, “things are really integrated at the beneficiary level.” Finally, they called attention to the importance of partnering with the MCOs. According to one state official: “We have built the program on involving our health plans [MCOs] as partners so we can solve problems together. You cannot presume as a state agency that you know every little detail and how it will work in the field.”

Endnotes

1 The state also operates Minnesota Senior Care Plus (MSC+)—a statewide Medicaid-only managed care program for people aged 65 and older. Enrollment in MSC+ is mandatory, but most eligible seniors have opted to enroll in MSHO instead. The MCOs contracted to provide MSHO services also deliver the MSC+ services. Both programs include the same managed LTSS; however, care coordination in MSHO is more robust because it also includes all Medicare services. Approximately 12,000 older adults are enrolled in MSC+.

2 During desk review, state agency staff review detailed documents submitted to the agency by the MCO that outlines certain processes. For example, the MCO might submit a detailed description of how it will train individuals who manage care coordinators. State agency staff review these documents to ensure they are comprehensive and describe a process that supports agency goals.

3 During onsite review, state officials go to the MCO’s offices to observe particular processes. Officials may, for example, go on site to see for themselves whether the MCO’s IT systems are functioning adequately,
or to conduct interviews with care coordinators. They may also inspect the premises to ensure the MCO is prepared to conduct business in accordance with contract requirements.

4 The state establishes additional MCO criteria in HCBS waiver documents and policy manuals. In addition, all participating MSHO MCOs must meet the requirements for fully integrated Medicare Advantage (MA) Dual Eligible Special Needs Plans [MCOs] (FIDE-SNPs). Medicare Advantage is a type of Medicare health plan [MCO] offered by a private company that contracts with Medicare to provide Medicare Part A (hospital services) and Part B (medical insurance) benefits. FIDE-SNPs were created by Congress in section 3205 of the Affordable Care Act. They are designed to promote the full integration and coordination of Medicare and Medicaid benefits for dual eligible beneficiaries by a single managed care organization. The MA SNP requirements also provide a basis for Minnesota’s readiness review.

5 Under Minnesota law, people who assess clients for LTSS are required to have a common set of skills and knowledge in best practices, and they are required to use person-centered principles. Training and certification help ensure consistency across assessments for people who require LTSS. To be eligible for the training, a person must have one of the following:

- A bachelor’s degree in social work plus at least 1 year of HCBS experience
- A bachelor’s degree in nursing with current licensure as a registered nurse, along with public health certification and at least 1 year of HCBS experience
- A degree in a closely related field plus at least 1 year of HCBS experience

6 The Money Follows the Person (MFP) Rebalancing Demonstration Grant Program helps states rebalance their Medicaid long-term care systems by providing funds to states to transition people with chronic conditions and disabilities from receiving their LTTS in institutional settings to receiving their services in community settings.

7 Staff from the MDHS Policy Unit and the Department on Aging collaborate with the MCOs to convene an ongoing care coordination work group. Care coordinator managers and staff members from each contracted MCO meet monthly to discuss and resolve issues related to the implementation of various care coordination processes. For example, the groups worked together to develop a care plan audit process and protocol.

8 A gap analysis is a technique used to determine what steps need to be taken to move from a current state to a desired, future state. Also called need-gap analysis, needs analysis, and needs assessment.

9 The state legislature enacted legislation in 1992 that created a 20-year strategy to increase the capacity of local long-term care services and resources to support older adults in the community. The program, now called Eldercare Development Partnerships, provides funds on a competitive basis to counties, health departments, social service agencies, housing providers, and AAAs. Funds may be used to (a) expand the capacity of community long-term care systems; (b) support the informal network of families, friends, and neighbors; (c) maximize people’s ability to meet their own long-term care needs; (d) align LTSS systems to support high-quality outcomes; (e) recruit and retain a stable long-term care workforce; and (f) reduce reliance on institutional care.

10 The following are ways that state officials said they monitor MCOs on an ongoing basis: monthly meetings with all plans [MCOs]; annual care plan audits; quarterly video conference trainings; tracking MCO data for timeliness of consumer assessments; ongoing oversight of compliance with [contract] requirements; regular communications with the ombudsman’s office about complaints, appeals, or calls they may be getting; monitoring of provider complaints; analysis of encounter data; review of ongoing reports submitted by the MCOs as part of their contractual requirements; regular meetings with stakeholder groups; and frequent telephone conversations with the MCOs. A state official said: “Through all of this, we get a good overall picture of how they [the MCOs] operate and we pretty much know their strengths and challenges.”