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

Lynda Flowers
AARP Public Policy Institute

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

STAR+PLUS—the Texas Medicaid managed long-term services and supports (LTSS) program—provides Medicaid-covered primary, acute, and LTSS to approximately 260,000 community-dwelling older adults and people with disabilities. To qualify for STAR+PLUS, individuals must be eligible for the full range of Medicaid-covered services. Beginning as a small pilot in 1998, the program now contracts with five managed care organizations (MCOs) to provide services in 89 counties. The program is administered by the Texas Health and Human Services Commission (THHSC), which houses the state's Medicaid agency. No other state agencies are involved in the readiness review process.

STAR+PLUS program officials believe the state has, as one official said, "a duty to assess [MCOs'] readiness before we go live." Thus, the state requires contracted MCOs to meet readiness review requirements (also called the transition phase). During this phase, STAR+PLUS program officials and MCO representatives work together to complete tasks associated with a detailed transition plan that has been developed by the MCO. Failure to meet state requirements during the transition phase exposes MCOs to financial penalties and can delay their ability to begin client enrollment.

The MCOs are responsible for developing a written work plan—known as the transition or implementation plan—used by THHSC to monitor MCO progress throughout the transition phase. According to one state official: "We treat the transition plan as a living document. The requirements for the transition plan are developed to meet the particular need and level of intensity of the necessary reviews." Officials noted that if the state is conducting a transition process with experienced MCOs, they may abbreviate the process that they would normally undertake for plans new to managed LTSS in the state.

One state official said: "Matching both the acute and the long-term care sides into an integrated model can be a complex organizational challenge [especially for newer MCOs]. So, we have to help [the MCOs] build the knowledge base on both sides. For example, an MCO might have a wealth of experience providing primary and acute care to vulnerable populations, but no experience with LTSS. If a state

contracts with this type of entity, it has to work closely with the new MCOs to help them develop a strong LTSS knowledge base so that it can adequately serve the population."

State officials in Texas said they use what one called a "risk-based approach to readiness review." Under this approach, state officials require MCOs new to managed LTSS to revise their transition plans as new client risks and needs are identified. According to one state official: "To manage that risk, you must focus on where the [beneficiary] risks are and where the organizations are placed. So, yes, you have your standardized documents and your set processes, but we [state officials] adjust the process according to where we assess risks and the need to know [other things that we did not anticipate when we developed the processes]." Officials indicated that this risk-based approach allows the state to be nimble when dealing with less-experienced MCOs rather than relying on a cookie-cutter process that may not "get you where you need to be." State officials believe that, as one official said, "you must have your systems working right, but you also must have on-the-ground competencies. They work together."

According to one state official: "It takes approximately four to five months to conduct a thorough readiness review, and we view the entire process as a partnership between the state and the MCOs." State officials said they are gratified when the MCOs tell them, "Your review has made us a stronger plan [MCO]."

Readiness to Provide Care Coordination Services

One state official said they "place a high priority on making sure that service coordinators are adequately trained."[1] Determining readiness to provide service coordination in Texas involves both desk[2] and onsite[3] review. Like the other study states, desk review involves a thorough examination of documents relevant to the care coordination process, such as training materials and staffing plans. The onsite review of the service coordination function does not occur until all relevant documents have been reviewed by state officials. State officials said that reviewing those documents in advance helps them to be more focused during their onsite review. According to one state official: "Thoroughly reviewing documents beforehand helps you to interpret what you are seeing and experiencing when you go onsite. … Onsite review is okay, but it's a big waste of time unless you've done your front-end work [thorough desk review] first."

Once on site, state officials interview a sample of service coordinators to determine whether they have received adequate training from the MCOs. To make this determination, state officials present service coordinators with various scenarios, and the service coordinators must discuss how they would respond to the specific situations.

In addition to scenario testing, state officials observe how service coordinators use the MCO's information technology (IT) systems to determine whether they understand how to order client services. For example, officials observe the service coordinator's ability to locate information related to the client—such as current services, authorizations, diagnoses, physicians used, and ordered medications—in the MCO's IT system. State staff also have conversations with a sample of service coordinators to ensure the person understands how to comprehensively address the client's needs. One state official noted that service coordinators "need to have a good understanding of (a) issues that impact older adults; (b) issues that are faced by people with disabilities; (c) issues encountered by physicians; and (d) issues involving long-term care providers."

Determination of LTSS Provider Network Adequacy

STAR+PLUS officials also use desk and onsite review to determine provider network adequacy. State officials view determining managed LTSS network adequacy as both "a science and an art."

Part of the science involves including language in the contracts that requires MCOs to contract with traditional LTSS providers. According to one state official: "You don't want people to lose continuity, so you try to get as many [traditional providers] as you can, and you try to protect the providers by making sure that contract provisions are favorable for them." State officials said that they push the MCOs hard to contract with all assisted living facilities and other [LTSS] providers in their catchment areas because, as one official noted, "this is where people live, and we don't want to see them displaced." State officials admitted that there are some areas where the state simply does not have a sufficient number of assisted living or adult day facilities to meet the need. As one official said, "It's a tough problem."

The art aspect of determining LTSS provider network adequacy is "seeing the flow of all the moving components and being able to determine whether the MCOs are able to be pragmatic and adapt to unanticipated circumstances related to network adequacy to ensure successful program implementation."

According to state officials, desk review involves state staff examination of documents such as (a) provider contracts; (b) provider payment rates; (c) provider training plans and manuals; and (d) a description of the provider appeals process. STAR+PLUS officials indicated they are especially focused on making sure MCOs include a sufficient number of home health, assisted living, and adult day care providers in their networks during desk review. They evaluate the contracted payment rate to determine whether it is adequate to secure provider participation in the program.

State officials re-examine the MCO's provider contracts when they conduct onsite review at the MCO's offices. During this part of the review, officials interviewed said they looked for the following:

- The LTSS provider contracts are accurately loaded into the MCO's IT system so that providers can bill and be paid in a timely manner.
- The MCO has accurately entered the contracted LTSS provider payment rate into its IT system.
- The MCO's IT system is functioning properly and is able to pay specified provider rates. One state official said this is important because "providers depend on their cash flow to be able to continue services, and beneficiaries depend on continued access to Medicaid to receive services."

State officials said another important focus of their onsite review is to determine whether the MCO's IT system can interface with the state's Medicaid management information system (MMIS)—the system used to determine Medicaid eligibility and enrollment. They consider this critical to ensuring continued access to LTSS services. In the words of one state official: "Our [the state's and the MCO's] capitation files and our eligibility and enrollment files have to communicate. These communications allow the MCOs to know (in real time) who their eligible enrollees are, and to receive monthly member capitation payments from the state." Being able to identify eligible enrollees in real time is critical to ensuring that people who need LTSS receive them in a timely manner.

Advice from State Officials

STAR+PLUS officials advise states to, as one official said, "look at everything and trust no one … not the providers, not the MCOs, not the subcontractors. You have to verify everything." In addition, state officials emphasized that MCOs with Medicare Advantage (MA)[4] experience still need help coming up to speed on the Medicaid side of things. According to one state official: "We see a lot of MA plans [MCOs] that want to get into the Medicaid managed [LTSS] business. They think their sophistication with the delivery of MA services to Medicare beneficiaries makes them a slam dunk. However, it is important for them [MA MCOs] to realize that MA does not equal Medicaid long-term care."

Endnotes

[1] The state uses the term "service coordinator" rather than "care coordinator."

[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] Medicare Advantage is a type of Medicare health plan offered by a private company that contracts with Medicare to provide Medicare Part A (hospital services) and Part B (medical insurance) benefits.

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AARP Public Policy Institute,
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3890, ppi@aarp.org