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

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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

The Wisconsin Department of Health Services (WDHS) oversees Family Care—Wisconsin’s Medicaid managed long-term services and supports (LTSS) program. Since 2000, Family Care has provided home- and community-based services (HCBS), nursing facility care, personal care, home health, and other Medicaid-financed managed LTSS to low-income Medicare beneficiaries who are enrolled in the state’s Medicaid program and receive the full Medicaid benefit package. The program, which is voluntary, provides services to approximately 37,000 frail adults aged 65 and older and to adults with physical, intellectual, and developmental disabilities. Family Care’s benefit package does not include Medicare-covered acute and primary health care, such as in-patient hospitalizations, emergency room visits, and primary care. The state’s Medicaid agency within the WDHS is primarily responsible for conducting readiness review—called certification by the state.

The Family Care program relies significantly on desk review to certify an MCO’s readiness to begin providing managed LTSS. Medicaid agency staff with different areas of expertise conduct desk review of documents submitted by the MCOs.

Readiness to Provide Care Coordination Services

The state uses both a desk review of written documents and onsite visits to MCO offices to determine whether MCOs are prepared to provide care coordination services to vulnerable clients from the first day of enrollment. According to state officials, the desk review portion of this process involves a complete review of written documents submitted to the state by the MCO. During this review, staff examine the documents to make sure they are consistent with contract requirements. Examples of those documents include the following:

- Care coordination training plans
- How patient-centered social and health assessments will be conducted (including a draft of the comprehensive assessment tool that will be used)
- The template that will be used to construct a member-centered care plan
The process that will be used to ensure that consumers receive needed services when a service provider fails to show

How the MCO will measure the quality of care coordination

The processes the MCO will use to monitor the quality of care coordination

State officials said they go on site to ensure the MCO has fully operational information technology (IT) systems needed to support member assessments and the authorization of needed services.

Officials also said that Medicaid agency staff play an active role in ensuring that care coordinators are adequately trained. During the pilot phase of Family Care, agency staff trained care coordinators for the MCOs. During the rapid expansion of Family Care between 2007 and 2011, the state continued the training but worked with MCOs to develop training and competency-development processes. Since then, the state has transitioned primary responsibility for training care managers to the MCOs.

Although primary responsibility for care coordinator training rests with the MCOs, the state is developing a state-funded, web-based training program. Topics that will be addressed in these web-based modules include the following:

- The history of long-term care in Wisconsin
- How to conduct client assessments
- How to develop a comprehensive care plan
- How to develop an individualized service package
- Successful strategies for working with an interdisciplinary team
- How to assess and address member risk

Care coordinator supervisors, MCO staff, and state officials participate in an ongoing work group to discuss problems that arise in the field, to identify solutions, and to identify and share best practices. In addition to these activities, the state contracts with an external quality review organization (EQRO) to conduct an annual review of the MCOs. As part of that review, the EQRO evaluates care coordination training programs for thoroughness and assesses the MCO’s implementation of care coordination program standards.

**Determination of LTSS Provider Network Adequacy**

Wisconsin Family Care uses desk review as the primary method for ensuring LTSS provider network adequacy. In addition to requiring MCOs to submit all of their provider contract templates for Family Care staff to examine, state officials require MCOs to provide written descriptions of a variety of tasks related to provider network adequacy. These include descriptions of the following:

- Processes the MCO will use to select and credential providers (including how the MCO will implement a process for criminal background checks)
- How the MCO will monitor providers
- Processes the MCO will use to identify provider shortages
- Strategies the MCO will use to address challenges in acquiring or developing a certain provider base (e.g., adult day care providers)
- The provider appeals process
- How the MCO will measure provider performance
- How the MCO will monitor whether clients are receiving the appropriate services
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- How the MCO will respond to client needs on a 24-hour basis
- How the MCO will ensure cultural competency in the delivery of services

A state official noted that “it takes time to develop robust provider networks.” MCOs that are expanding into new geographic areas may begin serving clients while developing their networks during the first months of operation and as new enrollees enter the program. State officials said they closely monitor MCOs as enrollees are phased into the managed LTSS program to ensure the provider network is sufficient to meet enrollees’ needs. If needed, officials require additional evidence. MCOs that are unable to provide this evidence are required to suspend enrollment pending further development of the provider network. The state may require the MCOs to allow enrollees to seek care from out-of-network providers (at the MCO’s expense), if the MCO lacks the capacity to provide a specific service. Going outside of the MCO’s provider network only works if there are adequate numbers of fee-for-service LTSS providers available to consumers.

State officials view the MCO’s provider claims payment IT system as an essential support to provider network adequacy because the ability to make timely payments to providers helps to ensure access. If providers are not receiving their payments on time, they might discontinue providing services, causing serious disruptions in needed services for vulnerable enrollees. One official said: “To ensure continuous access to needed services, it is imperative that MCOs have fully operational electronic claims payment systems in place, so that timely payments can be made to contracted LTSS providers.”

Advice from State Officials

One state official in Wisconsin said: “States should thoroughly assess the current condition of their delivery systems and have clear goals for their managed LTSS programs. The original Family Care pilot programs achieved success through methodical planning, and by taking the time to make sure that everything that touches the consumer was well thought through.” Officials also discussed the importance of including stakeholders in the design of the managed LTSS program. Finally, state officials attribute much of the success of their program to the fact that their counties (which had been providing managed LTSS services prior to managed care) formed themselves into managed care entities that were able to successfully compete for contracts to provide managed LTSS in the state. This, they said, may be a model that can be replicated in other states.

Endnotes

1 Wisconsin also has a fully integrated Medicaid-Medicare program called Family Care Partnership, which provides HCBS as well as all Medicaid- and Medicare-covered services to its members.
2 The state conducts onsite visits for newly contracted MCOs or for MCOs with existing managed care contracts with the state that are seeking to expand their service area.
3 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.
4 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.

5 Federal regulations (42 C.F.R. 438.354) define an EQRO as an independent organization with demonstrated experience and knowledge of Medicaid recipients, policies, data systems, and processes; managed care delivery systems, organizations, and financing; quality assessment and improvement methods; and research design and methodology, including statistical analysis.