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Strategies to Facilitate Managed Care Implementation for Medicare-Medicaid Enrollees

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IN BRIEF

Many states are working with health plans to develop new systems of managed care for vulnerable Medicare-Medicaid enrollees and individuals receiving long-term services and supports. As a result, states are developing early implementation strategies to smooth the transition of beneficiaries and providers from the fee-for-service environment into managed care. This brief focuses on key strategies used by Medicaid agencies in four states – California, Florida, Massachusetts, and Texas – to facilitate managed care implementation. The state strategies are organized into two areas: (1) leveraging health plan readiness review; and (2) monitoring implementation. These strategies can inform the launch of capitated integrated managed care programs or managed long-term services and supports (MLTSS) programs. The insights from these four states can also inform health plans working to manage beneficiary and provider transitions.

Many states plan to use managed care to coordinate the delivery of Medicare and Medicaid services including long-term services and supports (LTSS) for Medicare and Medicaid enrollees (also known as 'dual eligibles'). States participating in the capitated model of the Centers for Medicare & Medicaid Services' (CMS) Financial Alignment Initiative will contract with health plans to provide integrated Medicare and Medicaid services.[1] Other states are contracting with health plans to implement managed long-term services and supports (MLTSS) programs or integrated Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs) arrangements.[2]

Medicare-Medicaid enrollees have traditionally been carved out of Medicaid managed care, due in part to their often complex care needs involving many providers and the lack of incentives to coordinate all care without inclusion of Medicaid LTSS benefits. Avoiding disruptions in care is thus a key goal for states in implementing managed care for this population. Medicaid officials preparing to launch capitated arrangements for Medicare-Medicaid enrollees are challenged to ensure that: (1) individuals have the information they need to make sound enrollment decisions and access care options once enrolled; and (2) health plans are well equipped to deliver care and services.

This brief, developed through support of The Commonwealth Fund and The SCAN Foundation, examines strategies used by Medicaid agencies in four states – California, Florida, Massachusetts, and Texas – to facilitate smooth implementation of capitated financial alignment demonstrations or MLTSS programs. The strategies fit into two categories: (1) leveraging health plan readiness review; and (2) monitoring implementation.

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Leveraging Health Plan Readiness Review

Health plan readiness reviews include a comprehensive review of plan policies, procedures, systems, and operations by state staff including an assessment of plan readiness to support beneficiaries and providers at program launch. Critical areas for determining readiness include assessment of the plan's call centers, care managers, and claims and provider relations staff. An individual's first contact with a health plan is often a phone call to a customer service representative (CSR) to access services or a meeting with a care manager to complete an initial assessment. For providers, initial contacts with health plans are typically telephone inquiries related to service authorization or claims payment. Beneficiary and provider experiences during these initial contacts are enhanced by quick and correct transfer of calls, accurate transfer of information, and efficient resolution of issues that may impact access to care.

Before health plans are permitted to begin enrollment, states can use the onsite readiness review to determine plan readiness to answer beneficiary and provider questions and provide services. This is particularly important due to the unique needs of the Medicare-Medicaid and LTSS enrollee populations and the adjustment anticipated for LTSS providers who are unfamiliar with managed care. Under the capitated Financial Alignment Initiative, Medicare-Medicaid plans are required to undergo a joint readiness review process conducted by the state and CMS. States implementing Medicaid MLTSS programs also routinely conduct reviews to determine health plan readiness.

1. Conduct Onsite Reviews and Call Center Monitoring

Under Texas' STAR+PLUS MLTSS program, Medicaid officials developed onsite readiness reviews that included interviews with and observations of health plan CSRs, care managers, and claims and provider relations staff. During test calls with health plan CSRs, Texas' onsite reviewers use state-developed scenarios representing potential beneficiary or provider questions to test the capacity of health plan staff to respond to issues.[3] Texas Medicaid officials focus beneficiary scenarios on questions related to covered benefits and continuity of care periods. The state also uses ongoing "secret shopper" calls to confirm processes for call routing and transfers.

Confirming that CSRs and care managers fully understand continuity of care requirements and benefits information in the state contract is an important aspect of readiness assessment. CSRs answering initial beneficiary phone calls must clearly communicate key benefits and continuity of care protections, including services and treatments that are available for a defined period while initial assessments and care plans established. The state also uses direct observation and interviews to confirm care managers' understanding of assessment and care planning processes and service authorization protocols.[4] During interviews, Texas encourages CSRs and care managers to find answers to questions using their training materials or the health plan's information systems.

> "Texas uses direct observation and interviews to confirm care managers' understanding of assessment and care planning processes and service authorization protocols."

Texas also uses onsite readiness review to ensure that CSRs and claims and provider relations staff can respond to routine provider inquiries. This is done to minimize care disruptions that could occur if providers are unable to obtain timely service authorizations or payment. At the time of the readiness review and even before all plan staff have been hired or

trained, Texas reviews training materials and interviews the plan trainers to ensure they have sufficient knowledge to teach new staff. After the plan hires and trains staff in call centers, care management, and claims and provider relations, the state returns to conduct additional interviews and determine whether training was effective. The state also verifies that plans are able to pay pharmacy claims correctly to ensure that new enrollees, particularly those who may have multiple medications, can access needed medications. Medicaid agencies can design onsite readiness review protocols for new or expanding managed care programs that use simulations of beneficiary and provider experience navigating through new plan arrangements.

A sample of care manager interview questions used in past readiness reviews under the Texas STAR+PLUS program can be found in the Appendix.

2. Collect Data on Beneficiary and Provider Experiences

In Massachusetts, the state worked with the One Care Implementation Council and the University of Massachusetts Medical School to create the One Care Early Indicator Project (EIP) to collect measurable and actionable data during early stages of program operation.[5] The EIP uses qualitative and quantitative data from enrollment, focus groups, surveys, a state customer service team, the One Care Ombudsman, the state health insurance assistance program, and the One Care plans to assess beneficiary perceptions and experience.[6,7]

The first two EIP focus groups helped to identify: (1) the information used by prospective members to inform their decision to enroll or not enroll; (2) who prospective members spoke with about the program; and (3) where opportunities may exist to refine the information or processes used to educate beneficiaries about the new program. Although findings from small groups are not expected to be representative of Massachusetts' entire One Care population, the information can help identify emerging trends or issues. Early implementation focus groups can also be used for provider audiences.

Overview of Massachusetts' One Care Early Indicators Project

Goal

- Assess early perceptions and experiences of MassHealth members eligible for One Care using multiple methods (distinct from One Care programmatic evaluation or quality measures)

Qualitative Data Sources

- Five focus groups of eligible members: (1) early opt-ins; (2) early opt-outs; (3) Spanish speakers; (4) auto-enrollees; and (5) enrollees with intellectual disabilities and their caregivers
- Two surveys: (1) perceptions and experiences of One Care enrollees during initial enrollment period; and (2) comprehensive examination of beneficiary experience with continuity of care, assessments and care plans, care coordinator/LTSS coordinator experience, and successes/problems

Quantitative Data Sources

- Enrollments, MassHealth Customer Service, State Health Insurance Assistance Program, the One Care Ombudsman, the One Care plans

Early Indicators Project Workgroup

- Members: 4 Implementation Council, 3 MassHealth, 2 UMass Medical School
- Develops indicator metrics and evaluation tools
- Analyzes and reports data

3. Analyze and Respond to Feedback

Developing preemptive strategies for state oversight and response to beneficiary and provider concerns during early implementation can help states quickly address implementation issues. Florida Medicaid officials recently used several strategies to oversee the transition of more than 80,000 beneficiaries receiving either nursing facility or home- and community-based waiver services to a mandatory Statewide Medicaid Managed Care Long-Term Care (SMMC LTC) program.[8,9] To facilitate a smooth transition of the eligible LTSS population, Florida Medicaid officials used a phased enrollment approach across 11 regions, including: (1) a centralized

'complaint hub' and rapid problem resolution process; (2) an extended 60-day beneficiary choice period with one-to-one assistance; and (3) targeted policies and outreach practices to ensure continuity of care.[10]

To obtain direct feedback from beneficiaries and LTSS providers, Florida developed an online SMMC LTC complaint form and a centralized complaint hub to track and resolve all inquiries. Prior to implementation, the state provided education to beneficiary advocacy groups and LTSS provider associations on how beneficiaries, providers, and their representatives could submit feedback via the online form or directly to Medicaid field staff. During program roll-out for each region, the state monitored and triaged feedback 24 hours a day, seven days a week, prioritizing those that could impact beneficiary health, safety, or welfare. A morning issues meeting with key Medicaid operational staff was established to quickly resolve issues and develop messaging to relay to health plans on weekly calls.

According to Florida Medicaid officials, the centralized complaint hub acted as an early warning system for issues that could impact access to care and the morning issues meeting helped to rapidly identify trends in each region.[11] For example, in one region the state identified a trend in complaints regarding receipt of consumable medical supplies. The state's standing morning issues meeting enabled the agency to quickly identify the root cause of the issue while simultaneously employing agency staff and health plans to resolve impending beneficiary access problems. The centralized complaint hub was also used to inform a weekly implementation report that categorized complaints by region, plan, and provider type.

4. Conduct Ongoing Outreach and Education

Prior to the launch of its MLTSS program, Florida identified maintaining continuity of care as a key indicator of successful implementation – specifically defined as ensuring: (1) beneficiaries in home- and community settings received services without disruption; and (2) whenever possible, individuals residing in nursing facility and assisted living facilities did not have to move.[12] To facilitate continuity of care, the state conducted both outreach and education activities.

State Medicaid staff worked with staff at the Florida Department of Elder Affairs to place telephone calls to existing home- and community-based waiver services clients residing in their own home or a family member's home in which they verified that the waiver client continued to receive needed services during the transition into managed care. The staff also used these calls to triage any issues identified and funnel them into the state's centralized complaint hub. The state also proactively worked with existing Medicaid case management agencies to ensure smooth transition of beneficiaries' care plans to the new managed care plans.

> "Florida used multiple methods to educate and update providers regarding the new Medicaid managed long-term services and supports program."

Florida used multiple methods (e.g., state Medicaid agency guidance documents, provider bulletins, webinar trainings, regional stakeholder forums, weekly regional provider phone conferences, program facts sheets, and direct education via Medicaid field office staff) to educate and update providers regarding the new MLTSS program. To ensure continuity of care for new enrollees, the state developed clear policy guidance for LTSS providers regarding the state's transition period to avoid service disruption. Florida instructed existing LTSS providers to continue providing services for up to 60 days after a beneficiary's enrollment in a plan or until the provider received instructions from the beneficiary's plan. For assisted living facilities and nursing facilities, the state also issued guidance

regarding provider responsibility to cooperate with plans entering facilities to complete assessments and to share information on existing plans of care. These practices helped the state to successfully launch the new SMMC LTC program while minimizing any disruptions in care for vulnerable LTSS enrollees.

Conclusion

The strategies used by California, Florida, Massachusetts, and Texas illustrate how states can tailor readiness reviews, oversight, stakeholder engagement, and early measurement approaches to support beneficiary and provider transitions to integrated Medicare-Medicaid or MLTSS programs. Facilitating smooth implementation of new integrated systems of care for vulnerable Medicare-Medicaid populations with significant care needs is a central goal of states, stakeholders, federal partners, and health plans. The early implementation strategies profiled here can help states achieve this goal by allowing for rapid resolution of unanticipated issues and creating valuable mechanisms to capture feedback from the beneficiaries and providers all parties are eager to support.

Appendix: Texas STAR+PLUS Program Sample Care Manager Interview Questions

Following are sample interview questions from a readiness tool recently used by Texas Medicaid for its STAR+PLUS MLTSS program.[13] The state staff interviewing the care managers (called service coordinators in Texas) must have a throrough knowledge of the plan's model of care, policies, and procedures. The state interviewers are trained to use interviewees' responses to generate further questions or investigations. After the interviews, the state readiness review team identifies issues that still need clarification by the health plan.

Sample Interview Questions for Texas STAR+PLUS Service Coordinators

Role and Responsibilities

- What is your primary responsibility toward your assigned members?
- How would you define Service Coordination?

Assessment and Reassessment

- How many members are in your caseload?
- How long after enrollment is a member assigned to your caseload, and how quickly are you required to make contact? Is the contact by phone or in person?
- How frequently do you visit the members in your case load?
- What do you do if you cannot make contact with the member?
- What do you do if a provider calls to prescribe services due to a change in the member's condition? Who gets the calls and where are they tracked and logged? And what do you do to follow-up on this issue? What is the timeline for follow-up?

Covered Services

- What services are covered for STAR+PLUS members?
- Do dual eligible members have any dental benefits? Where is this information found?

Care Plan Development

- What do you do if a member reports that the attendant did not show up for work and the Agency cannot send a replacement?
- What is an inter-disciplinary service plan? What does it contain? Does the member sign it? When?
- How is an inter-disciplinary service plan developed and when is it signed by the member?
- How do you document the outcome of a reassessment that results in a reduction in services?
- How is a member notified of a reduction in services?
- Who does the member call to request an appeal or fair hearing?

Care Transitions

- What does a member do if they want to keep their benefits at the same level while awaiting the Fair Hearing?
- What do you do if you find out that one of your assigned members is being discharged from the hospital?
- How does a member access the named service coordinator? What are the expectations for the member to receive a response from the service coordinator?
- How much time do you have to complete the assessment for clients transitioning from a NF?

Access to Services

- What do you do if a member assigned to you, calls and needs to see her PCP in 3 days? She has no transportation to get to her appointment. What if the member is dual eligible? Does this change your answer? If so, how?
- Member calls and can't find a doctor, what actions do you take? What is the timeline for you to take these actions?
- What do you do if a member needs to see a doctor that is not in your network? What if the member is Dual Eligible? What is the timeline for you to take these actions?
- One of your Provider agencies states that they can no longer provide service to a member because the member needs night nursing and the agency does not provide services from 7pm to 8am. What steps/actions do you take?
- Describe the necessary coordination for members with intellectual or developmental disabilities. And, for long-term services and supports? What is the timeline?

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care. In collaboration with state and federal agencies, health plans, providers, and consumer groups, CHCS pursues innovative and cost-effective strategies to better serve Medicaid beneficiaries. Its program priorities are: enhancing coverage and access; integrating care for adults and children with complex needs; improving quality and efficiency through delivery system reform; and building Medicaid leadership and capacity.

Endnotes

[1] Through the Financial Alignment Initiative states have partnered with the Centers for Medicare & Medicaid Services (CMS) to design new models of care intended to better integrate Medicare and Medicaid services, improve care delivery, and reduce unnecessary spending. States participating in the initiative have selected either a capitated or a managed fee-for-service model. Eleven states are working with CMS to develop and implement capitated models; California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, Virginia, and Washington.

[2] Dual-Eligible Special Needs Plans (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid). D-SNPs may combine benefits available through Medicare and Medicaid.

[3] Presentation by Paula Swenson, Director of Program Support and Utilization Management, Texas Health and Human Services Commission, on September 26, 2013, at a CHCS meeting with states participating in the Implementing New Systems of Integration for Dual Eligibles (INSIDE) initiative. Support for the INSIDE initiative is provided by The SCAN Foundation and The Commonwealth Fund.

[4] Ibid.

[5] Presentation by Michele Goody, MassHealth, Director of Cross Agency Integrated Care Coordination to states participating in the CHCS led Implementing New Systems of Integration for Dual Eligibles (INSIDE) initiative, November 20, 2013.

[6] Ibid.

[7] All financial alignment demonstrations will undergo a formal evaluation of their ability to improve quality and reduce costs. CMS requires that states collect and track data on a wide-array of metrics related quality and cost outcomes for their targeted demonstration population. The focus groups and surveys used by Massachusetts' EIP are being conducted in addition to the formal national evaluation. Additional information on national and state specific evaluations can be found at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html. Formal quality improvement and assessment requirements and frameworks also apply to MLTSS and D-SNP programs.

[8] Additional information on Florida's Statewide Medicaid Managed Care (SMMC) Long-term Care Program is available here: http://ahca.myflorida.com/medicaid/statewide_mc/ltchome.shtml.

[9] As part of the state's overarching SMMC 1115 waiver, the new program included the consolidation of five existing home- and community-based waivers into one LTC program service package. The LTC component of SMMC enrolls frail and disabled individuals 18 years of age or older who meet state nursing facility level of care criteria.

[10] Interview with Florida Medicaid officials, April 10, 2014.

[11] Ibid.

[12] Ibid.

[13] Sample service coordinator readiness review tool supplied by Paula Swenson, Director of Program Support and Utilization Management, Texas Health and Human Services Commission.