



**Keeping Watch:  
Building State Capacity to  
Oversee Medicaid Managed  
Long-Term Services and Supports**

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**Research Report**

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AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

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## EXECUTIVE SUMMARY

A growing number of state Medicaid agencies are planning to launch or expand programs that offer risk-based contracts to managed care organizations (MCOs) to provide long-term services and supports (LTSS)—and, in some cases, acute and primary care—to older adults and people with disabilities. Because these individuals often have one or more chronic health conditions, they tend to use more health services than younger people and people without disabilities. In addition, they often depend on other services and supports such as personal care to perform activities of daily living, such as bathing and eating.

In risk-based managed care arrangements, state Medicaid agencies pay their contracted MCOs a predetermined monthly per-member rate and the MCOs bear financial risk for providing all covered services within the rate. These fixed payments make Medicaid costs more predictable for state governments, but they may create incentives for plans to restrict access to services for individuals who have costly health care needs.<sup>1</sup> This potential risk highlights the importance of state oversight to ensure that MCOs comply with all contract requirements—including the provision of all LTSS required to provide optimal care to their enrollees.

This study was conducted to determine the specific capacities that state Medicaid agencies need to monitor the performance of managed LTSS (MLTSS) programs. It sought to identify promising practices in state oversight as well as the monitoring capacities that should be in place when states begin to implement new or expanded MLTSS programs. Lessons were drawn from oversight practices in eight states that have many years of experience operating and overseeing MLTSS: Arizona, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, and Wisconsin. References to “states” in this report are to these eight states unless otherwise specified.

## Findings

- **State MLTSS programs vary along several dimensions:** First, they vary in the length of time they have been operating, from two years in Tennessee to more than 20 years in Arizona. Second, they vary in the number of managed care plans they contract with to provide MLTSS, from two in New Mexico to 14 in New York. They also vary in the number of enrolled beneficiaries receiving MLTSS, from about 15,000 in Massachusetts to more than 260,000 in Texas, soon increasing to 315,000. Finally, state programs vary in the range of services they cover, from programs that are limited to providing home and institutional LTSS, like the Wisconsin’s Family Care Program and New York’s Managed Long-Term Care programs, to those that cover acute care, primary care, pharmacy services, LTSS, and behavioral services in the other states. These differences may explain some of the variation in the resources states need to devote to MLTSS oversight.

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<sup>1</sup> J. Connolly and J. Paradise, “People with Disabilities and Medicaid Managed Care: Key Issues to Consider,” Kaiser Commission on Medicaid and the Uninsured, Issue Brief, Pub. No. 8278 (February 2012); J. Holahan, S. Zuckerman, A. Evans, and S. Rangarajan, “Medicaid Managed Care in Thirteen States,” *Health Affairs* 17(3):43–63, May/June 1998.

- **Over time, most of the states had gradually consolidated contract monitoring functions for MLTSS with other Medicaid managed care operations. We call this the integrated oversight model.** State officials believe that the integrated oversight model makes it easier to share and analyze information related to all aspects of MCO operations; take advantage of existing managed care oversight infrastructure to perform core functions, such as developing contract language, setting capitation rates, and establishing provider network and quality standards; and reduce duplication of effort and use staff resources more efficiently.
- **All of the states used the skills and resources of many other organizations to enhance or strengthen their MLTSS oversight capacity.** Partners included (1) external quality review organizations (EQROs), which evaluate the quality of care provided to beneficiaries and help MCOs to improve their quality, and, in four states, review MCO care management and care coordination processes; (2) state staff in health, aging, or disability departments, who provide expertise in monitoring LTSS provider networks and LTSS quality; and (3) consumers or consumer advocacy groups, which help design, monitor, and evaluate program performance.
- **State capacity to oversee MLTSS program performance requires staff with the right mix of skills and experience, as well as information system expertise.** Staff should have strong qualifications in core oversight functions: program management, contract monitoring, provider network adequacy, quality assessment, beneficiary rights and education, and rate setting. Effective contract monitoring also depends on robust information technology (IT) systems that can track MCO reporting and integrate data from many sources to produce overall performance indicators within and across the MCOs.
- **The states differed in how they carried out core MLTSS oversight functions.** This project identified five core areas that are critical for states to focus on for comprehensive oversight of MLTSS contracts: contract monitoring and performance improvement; provider network adequacy and access to services; quality assurance and improvements; member education and consumer rights; and rate setting.

In carrying out oversight responsibilities in the five core areas, we found that state oversight practices fall into three categories: (1) *norms*, which are practices required by federal rules or used in most of the states; (2) *promising practices*, which go beyond federal regulations, may help to improve plan performance or yield better beneficiary outcomes, and often involve more frequent review or require greater capacity or resources than are typical in most of the states; and (3) *caution flags*, which can pose a risk to beneficiaries or to achieving program goals because they involve sporadic or cursory oversight and monitoring of plan performance. This report describes these practices in detail for four of five core oversight functions listed above.<sup>2</sup> The following are examples of promising practices:

— *Contract monitoring and performance improvement*—Using software tools or onsite IT audits to review MCO submission of all required data and reports on

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<sup>2</sup> A fifth core oversight capacity (rate setting) is discussed in the report, but the highly technical nature of the issues precluded a detailed examination.

- schedule; offering financial incentives or bonuses to plans that meet or exceed performance targets.
- *Provider networks and access to services*—Using visits, calls, and “mystery shoppers” to ensure that all providers on MCO network lists are actually available and accessible to enrollees.
  - *Quality assurance and improvement*—Using real-time service-monitoring tools, such as electronic visit verification systems, to monitor home care delivery; analyzing encounter data and other information to create a comprehensive set of quality indicators; and posting up-to-date information on MCO quality indicators on state websites.
  - *Member education and consumer rights*—Operating ombudsman programs specifically dedicated to investigating and resolving MLTSS member problems.

**Room to build capacity in all states.** Experience suggests that the more Medicaid agencies integrate these oversight functions and use information from all domains to evaluate plan performance, the more leverage they have for improving beneficiary and LTSS system outcomes. Because states that are now starting to plan and operate new MLTSS programs may find it difficult to put in place the organizational structure, staffing, and norms in oversight functions typical of experienced states, the report offers guidance on the oversight capacities that should be in place to ensure smooth implementation on “day one” when beneficiaries begin to enroll in plans.



## INTRODUCTION

This study was conducted to determine the capacities that states need to oversee the performance of Medicaid managed care plans that deliver long-term services and supports (LTSS) to vulnerable older adults and people with disabilities. It sought to identify promising practices in state oversight as well as the monitoring capacities that, ideally, should be in place when states begin to implement new managed LTSS programs.

Rising Medicaid costs and continuing fiscal pressures are leading state governments to look for savings by enrolling more Medicaid beneficiaries into managed care plans.<sup>3</sup> In the past, older adults and people with disabilities made up relatively small shares of Medicaid managed care enrollees, and those who use LTSS were often excluded from such arrangements. However, state Medicaid programs are increasingly considering risk-based contracting with managed care organizations (MCOs) to provide LTSS—and often acute and primary care as well—to those enrollees. This year, as many as 20 states are expanding or plan to introduce risk-based managed care programs for Medicaid beneficiaries needing LTSS.<sup>4</sup> Such contracts place the plans at financial risk by making monthly per-member payments to the plans in advance, thereby making Medicaid costs more predictable for state governments. The downside of this arrangement is the risk that plans may restrict access to services for enrollees with costly health care needs.

Ensuring that older adults and people with disabilities enrolled in managed care plans receive all the services they need when they need them, and that services are consumer-focused and support quality of life, requires strong state oversight and monitoring. The Center for Health Care Strategies cited “robust contractor oversight and monitoring requirements” as one of the top 10 milestones that states should strive to achieve in developing and implementing managed LTSS (MLTSS) programs.<sup>5</sup> The Kaiser Commission on Medicaid and the Uninsured called attention to the need for vigilant state oversight efforts, such as measuring plan performance and involving consumers and providers in monitoring program operations, as one of five key issues for states considering a shift to MLTSS.<sup>6</sup>

Yet state Medicaid agency resources are already strained. State budget shortfalls in the past few years have led to staff reductions and in some cases, hiring freezes in state and local governments. Medicaid agencies face many competing priorities, including the need to prepare for a flood of new Medicaid enrollees in 2014 due to an expansion of Medicaid eligibility under federal health care reform, and to make future upgrades to claims payment systems and billing codes to conform to ICD-10 (an updated diagnostic

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<sup>3</sup> K. Gifford, V. K. Smith, D. Snipes, and J. Paradise, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2011).

<sup>4</sup> M. Cheek, M. Roherty, L. Finnan, E. G. Cho, J. Walls, K. Gifford, W. Fox-Grage, and K. Ujvari, *On the Verge: The Transformation of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, February 2012).

<sup>5</sup> A. Lind, S. Gore, L. Barnette, and S. Somers, *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services* (Center for HealthCare Strategies, November 2010).

<sup>6</sup> L. Summer, *Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2011).

coding system used by all payers and providers). As more states develop integrated care programs for people who are eligible for Medicaid and Medicare, consumer groups are calling for more comprehensive coordinated oversight systems between states and the federal government, in collaboration with consumers and key stakeholders.<sup>7</sup>

## Methodology

In August 2011, the AARP Public Policy Institute (PPI) commissioned Mathematica Policy Research to investigate MLTSS contract oversight practices in a sample of states. The project was guided by an Advisory Group (see acknowledgments) that helped to develop a discussion guide (appendix A) and recommend states to include in the study. To understand how their oversight operations have evolved over time and to learn from their experience, we selected eight states that have operated and overseen MLTSS programs for at least two years: Arizona, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, and Wisconsin. References to “states” in this report are to these states, unless otherwise specified.

Over a four-month period, we interviewed 23 senior state Medicaid officials and one representative from a quality review contractor in these states. The interviews were guided by discussion questions on topics related to state oversight of MLTSS, including how each state (1) organizes and staffs oversight functions within the Medicaid agency and with other partners; (2) involves consumers and other stakeholders in program planning and assessment; (3) monitors provider network adequacy, access to care, and quality of care; (4) educates beneficiaries and protects consumer rights; and (5) enforces contract requirements and motivates plans to improve performance. State officials were given an opportunity to review a draft of this report to correct any inaccuracies before it became final.

We also asked the states to provide updated information on their MLTSS program characteristics, reviewed publicly available program reports and performance measures, and requested additional information on a range of LTSS topics, such as oversight of comprehensive needs assessment, individualized care planning, and care coordination. Senior researchers from the AARP PPI reviewed the contracts for each state MLTSS program and provided written summaries to inform the interviews. In addition, we asked some MLTSS veterans—individuals with many years of experience managing such programs, some of whom no longer work in state government—to identify oversight capacities that they believe are critical for states to have in place *before* they allow plans to begin enrolling older adults and people with disabilities.

In addition, on December 7, 2011, the AARP PPI convened a roundtable meeting with representatives of federal and state governments, managed care plans, consumer advocacy groups, and other experts to review and discuss preliminary findings from the study. We solicited their ideas on how to maximize the usefulness of this report to federal and state Medicaid officials as they plan their oversight activities to monitor plans that provide MLTSS for vulnerable adults and individuals with disabilities.

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<sup>7</sup> L. Prindiville and G. Burke, “Ensuring Consumer Protection for Dual Eligibles in Integrated Models,” Issue Brief (National Senior Citizens Law Center, July 2011).

## State Programs Vary

State MLTSS programs vary along several dimensions (see table 1). First, they vary in the length of time they have been operating, from two years in Tennessee to more than 20 years in Arizona. Second, they vary in the number of managed care plans they contract with to provide MLTSS, from two in New Mexico to 14 in New York. They also vary in the number of enrolled beneficiaries receiving managed LTSS, from about 15,000 in Massachusetts to more than 260,000 (soon increasing to 315,000) in Texas. Finally, they vary in the range of services they cover, from programs that are limited to providing home and institutional LTSS, like the Wisconsin’s Family Care Program and New York’s Managed Long-Term Care programs, to those that cover acute care, primary care, pharmacy services, LTSS, and behavioral services in the other states.<sup>8</sup> In discussions with state officials and in our analysis, we explored whether these differences could explain some of the variation in the resources states need to devote to MLTSS oversight.

## Guiding Principles

This study was guided by four key principles that emerged from discussions among Advisory Group members and roundtable meeting participants.

The first guiding principle **affirms the importance of state oversight to ensuring the delivery of high-quality, person- and family-centered, cost-effective care for older adults and people with disabilities.** Federal and state officials share responsibility for overseeing and enforcing laws and regulations that govern Medicaid managed care programs, but states are “first responders” in ensuring that consumers receive high-quality care and in protecting their legal rights. Although contracts between states and MCOs establish standards and requirements, such contracts are empty promises if states are unable to monitor and enforce plan compliance and performance. Specific state oversight and monitoring activities will depend on contract requirements, but all states should be able to carry out core oversight functions to monitor and ensure contract compliance, improve plan performance, and achieve overall program goals. In addition to overall program management, core oversight functions include (1) monitoring contracts and performance improvement, (2) ensuring adequate provider networks and access to services, (3) ensuring and improving quality, (4) providing member education and protecting consumer rights, and (5) setting appropriate rates. Although data are not yet available, robust state oversight of Medicaid MLTSS may contribute to improved beneficiary and LTSS system outcomes.

The second guiding principle holds that **effective oversight of Medicaid managed care programs for older adults and people with disabilities requires particular capacities that differ from those required to oversee standard managed care plans covering acute and primary care services for younger people without disabilities.** People who need LTSS are, by definition, those who rely on hands-on personal assistance to carry out activities of daily living (ADLs) such as getting out of bed, walking, bathing, toileting, dressing, and eating. Ensuring that these services are provided consistent with an individual’s plan of care requires specialized attention and oversight by plan managers

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<sup>8</sup> About 30 state Medicaid programs cover managed LTSS through Programs of All-inclusive Care for the Elderly (PACE). Since oversight of PACE programs is governed largely by federal rules, this study did not examine state oversight practices.

**Table 1**  
**MLTSS Program Characteristics**

State Program Name, Start Date	Number Enrolled (latest available)	Number of Plans	Services Covered
<b>Arizona</b> AZ Long Term Care System (ALTCS), 1989	51,456 (9/2011)	5 <sup>a</sup>	Medicare acute (in plans with SNP contracts), Medicaid acute, LTSS (including HCBS and NF), behavioral health, pharmacy
<b>Massachusetts</b> Senior Care Options (SCO), 2004	14,676 (7/2010)	4	Medicare acute, Medicaid acute, LTSS (including HCBS and NF <sup>b</sup> ), behavioral health, pharmacy
<b>Minnesota</b> MN Senior Health Options (MSHO), 1997	36,500 (1/2012)	8	Medicare acute, Medicaid acute, LTSS (including HCBS and NF <sup>c</sup> ), behavioral health, pharmacy
MN Senior Care Plus (MSC+), 2005	11,500 (1/2012)	8 <sup>b</sup>	Medicaid acute, LTSS (including HCBS and NF <sup>c</sup> ), behavioral health, pharmacy
Special Needs Basic Care (SNBC), 2008	10,500 (1/2012)	5	Medicare acute (in plans with SNP contracts), Medicaid acute, limited LTSS, <sup>d</sup> behavioral health
<b>New Mexico</b> Coordination of Long-Term Services (CoLTS), 2008	38,401 (1/2011)	2	Medicare acute, Medicaid acute, LTSS (including HCBS and NF), pharmacy
<b>New York</b> Medicaid Advantage Plus (MAP), 2007	1,580 (includes PACE) (10/2011)	8	Medicare acute, Medicaid acute, LTSS (including HCBS and NF), limited behavioral health
Managed Long-Term Care (MLTC), 1997	35,403 (10/2011)	14	LTSS only (including HCBS and NF)
<b>Tennessee</b> CHOICES, 2010	~30,000 (10/2011)	3	Medicaid acute, LTSS (including HCBS and NF), and behavioral health; dental (for children only) and pharmacy through separate plans
<b>Texas</b> STAR+PLUS, 1998	~259,200 (8/2011)	5	Medicaid acute, LTSS (including HCBS and NF), limited behavioral health, pharmacy
<b>Wisconsin</b> Family Care, 2000	33,292 (9/2011)	10	Medicaid LTSS (including HCBS and NF)
Family Care Partnership, 1995	4,742 (9/2011)	4	Medicare acute, Medicaid acute, LTSS (including HCBS and NF), behavioral health, pharmacy

HCBS = Home and community-based services; NF = Nursing facility services; SNP = Special Needs Plan

<sup>a</sup> ALTCS has contracts with four plans and the Department of Economic Security.

<sup>b</sup> The same eight plans contract with both MSHO and MSC+ programs.

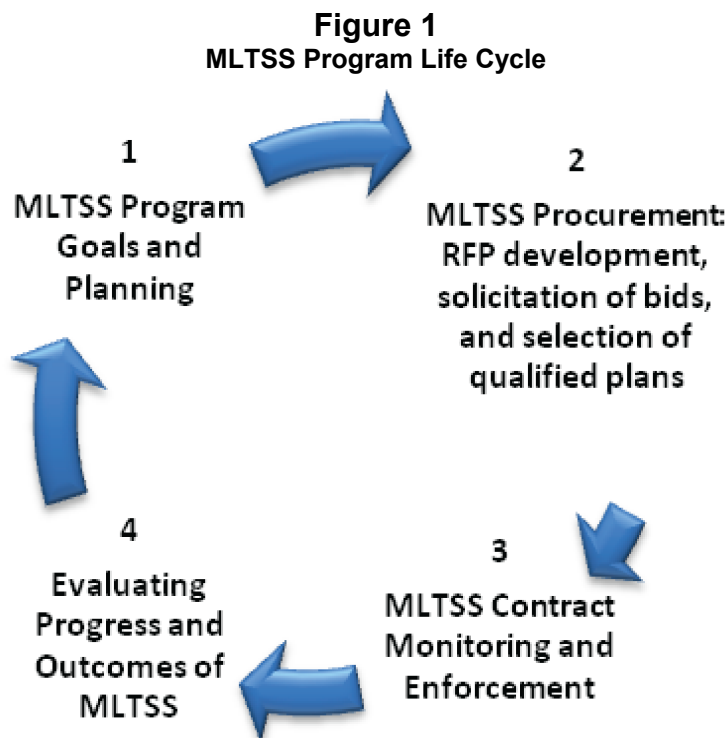
<sup>c</sup> MSHO and MSC+ include only the first 180 days of NF care in the capitation; all other services remain covered under the plan for NF residents.

<sup>d</sup> SNBC LTSS services include only skilled registered nurse visits, home health aides, and 100 days of Medicaid nursing facility stays; all other services remain covered under the plan for NF residents. Excludes personal care and waiver services.

and state Medicaid agencies alike. In addition to using more LTSS, older adults and people with disabilities often have multiple chronic conditions and use more health services than younger people without disabilities. This highlights the importance of ensuring that enrollees and their family caregivers, if appropriate, have access to a wide range of services in accordance with their needs and preferences, and that their care is coordinated across many types of providers and care settings. Special attention should be given to including and supporting family caregivers (as appropriate) and include them (along with the enrollee) as important contributors to the care team.

The third guiding principle maintains that **all states have room to build upon and improve their capacity to oversee MLTSS programs**. This study found differences in how even experienced states carry out core oversight functions, some of which go beyond the floor set by federal regulations or have more potential to improve outcomes. A number of factors also drive the need for states to continually improve capacity: (1) many oversight processes require specialized knowledge and skills; (2) effective oversight often requires close coordination among staff and other partners; (3) turnover in state employees, or staffing cuts during economic downturns, require new personnel to be trained; and (4) better ways of monitoring plan performance emerge from new information technologies. The classification of oversight and monitoring practices into norms, promising practices, and caution flags, discussed in the Core Capacities for Monitoring MLTSS Contracts section, can help each state benchmark its current approaches with those in other states, and identify specific capacities that could be improved.

The fourth guiding principle, closely related to the third, is that to perform effective MLTSS oversight, **state capacity should be developed before new programs begin to enroll beneficiaries**. The life cycle of managed care program oversight (figure 1)



includes four steps, beginning with setting overall program goals and planning key program design features. It then proceeds to procurement, in which requests for proposals (RFPs) or bids from MCOs are developed, and the state selects well-qualified MCOs. After signing contracts with MCOs, the third step involves monitoring MCO compliance with contract terms and assessing overall performance. The fourth step involves regular evaluation of progress toward goals, which feeds back into setting new goals and redesigning the program. State oversight capacity is important to each of these steps and should be developed before plans begin serving beneficiaries. Although oversight encompasses all four steps, the term “monitoring” in this report generally refers to the activities in the third step, after the contract is signed.

### **Road Map to the Report**

This report is divided into three main sections:

- Organizational Models, Partners, and Key Inputs
- Core Capacities for Monitoring MLTSS Contracts
- State Readiness to Implement New MLTSS

The section on Organizational Models, Partners, and Key Inputs explains the various ways in which Medicaid agencies organize their oversight functions. It also discusses how states partner with other entities to accomplish effective oversight. It identifies the key staff skill sets and information technology (IT) requirements that promote effective MLTSS oversight.

The section on Core Capacities for Monitoring MLTSS Contracts focuses on how states conduct five core contract-monitoring activities and classifies these activities into norms, promising practices, and things that raise caution flags. The section also discusses how state monitoring practices can contribute to improved beneficiary outcomes.

The section on State Readiness to Implement New MLTSS Programs discusses the oversight capacities that veteran program managers believe are essential for states planning new MLTSS programs to have in place before enrolling members. It is designed as a readiness review checklist to help states determine whether they have the capacity to monitor plan performance on “day one.”

A brief conclusion acknowledges the challenges associated with conducting effective oversight of MLTSS programs and emphasizes the importance of using partners and new resources to build oversight capacity.



## ORGANIZATIONAL MODELS, PARTNERS, AND KEY INPUTS

Effective oversight of MLTSS programs requires state Medicaid agencies to coordinate and integrate monitoring functions within the Medicaid agency and across many partners, including staff in other state agencies, local government entities, vendors, and consultants, as well as consumer representatives and other key stakeholders. This section describes the organizational models used by the eight study states to structure and manage program oversight (table 2); the role and contributions of key partners; key staff skills for effective oversight; and the role of IT.

### Organizational Models

Before starting their MLTSS programs, the study states had years of experience with risk-based capitated managed care plans to provide acute and primary care to children and adults without disabilities. Thus, they could build upon an existing oversight infrastructure when they began their MLTSS contracts. When first introduced, MLTSS programs were often designed and overseen by a separate dedicated unit that, in many cases, had previously managed the fee-for-service (FFS) long-term services and supports. But over time, six of the eight states have merged and consolidated most MLTSS plan monitoring

**Table 2**  
State Organization and EQRO Functions

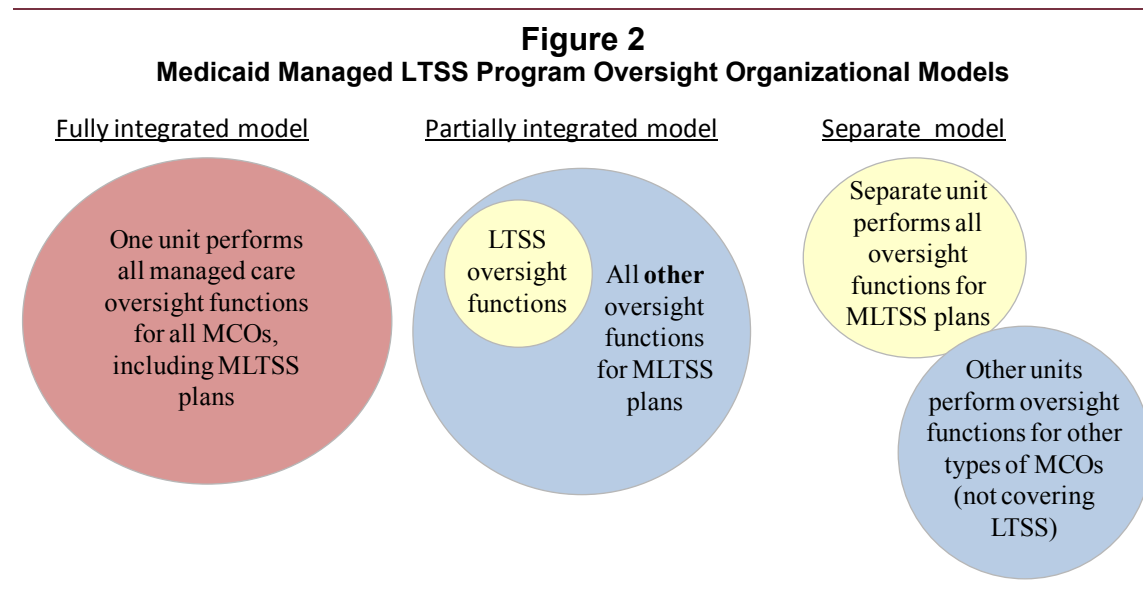
State	Degree of Integration of Managed LTSS and Other Managed Care Oversight	External Quality Review Organization (EQRO) Functions
Arizona	Fully integrated	Mandatory functions only
Massachusetts	Separate (but coordinated with federal CMS)	Mandatory functions only
Minnesota	Fully integrated	Mostly mandatory functions, though EQRO does occasional care management reviews
New Mexico	Partially integrated	Mandatory functions only
New York	Partially integrated	Beside mandatory functions, EQRO is creating a tool to validate member functional assessment scores.
Tennessee*	Partially integrated	Beside mandatory functions, the EQRO reviews effectiveness of care coordination.
Texas	Fully integrated	Beside mandatory functions, EQRO reviews LTSS care plans to verify service delivery and coordination.
Wisconsin	Separate	Beside mandatory functions, EQRO conducts care management reviews.

CMS = Center for Medicare and Medicaid Services.

\* In addition to review of home and community-based services quality in CHOICES plans, Tennessee's Medicaid LTSS quality assurance division also oversees the Money Follows the Person demonstration, PACE, and Area Agencies on Aging and Disability.

functions into their broader Medicaid managed care oversight infrastructure. State officials cited many advantages of an integrated oversight structure. It is easier to share information on multiple aspects of MCO operations, reduces duplication of effort across agencies and divisions, and uses resources more efficiently. It also is easier to monitor trends or shifts in use of acute, post-acute, LTSS, and behavioral services over time.

However, states still use different organizational models for MLTSS oversight, which are distinguished by (1) whether they retain a distinct unit within the Medicaid agency dedicated to carrying out LTSS oversight functions (fully integrated models do not), and (2) the range of oversight responsibilities associated with dedicated LTSS units in states that have retained them. In partially integrated models, the unit performs functions related to the LTSS provided in MLTSS programs, and in separated models, the unit performs all (or most) managed care oversight functions for MLTSS plans. Note that the distinction between partially integrated and separated models is not the degree to which they communicate or coordinate with other Medicaid staff, but rather the range of oversight functions carried out by the dedicated LTSS unit. These models are illustrated in figure 2 and explained further below.



- **Fully integrated.** In a fully integrated model, all MLTSS contract monitoring functions are performed by the same staff who monitor Medicaid managed care plans for younger populations without disabilities covering acute and primary care. The states that use this model (Arizona, Minnesota, and Texas) cover the entire continuum of care, from acute care and primary care to behavioral LTSS. Because they expect the MCOs to coordinate these services for enrollees, a fully integrated oversight model gives state agencies a comprehensive view of the entire service package. State managers from these three states regard this model as a more efficient use of staff and believe that it makes it easier to cross-fertilize knowledge and skills.



- **Partially integrated.** In the partially integrated model used by New Mexico, New York, and Tennessee, responsibility for overseeing LTSS contract requirements is assigned to a dedicated unit within the Medicaid agency that deals with all LTSS, whether through managed care or FFS arrangements. The MLTSS unit coordinates with other Medicaid agency divisions or units that conduct oversight functions common to all managed care contracts. For example, the LTSS group might review the adequacy of LTSS provider networks, monitor service quality and access for older adults and people with disabilities, and assess compliance with care management requirements. Meanwhile, other units in the Medicaid agency would set rates, oversee plan finances, and monitor primary and acute care delivered both for plans that cover LTSS and plans that do not. This collaborative model ensures that major oversight activities are carried out by people who are experienced with LTSS and also, according to one state official, “facilitates consistent policies across all LTSS programs.”
- **Separated.** Massachusetts and Wisconsin assign responsibility for overseeing MLTSS plans to a Medicaid unit, which is separate from the Medicaid agency units that oversee managed care plans covering beneficiaries who do not use LTSS. This model allows MLTSS staff to give more attention to the specific needs of the populations enrolled in MLTSS plans and more support to the plans and providers. However, the model can result in some redundancy if staff from the separate unit perform some of the same functions as other Medicaid staff, and can make it harder to coordinate overall plan oversight.

### The Role of Other Partners in Managed LTSS Program Oversight

In addition to other divisions within the Medicaid agency, we asked state officials whether they rely on other public or private sector entities to assist in MLTSS oversight.<sup>9</sup> All eight states do so, although to different degrees. For example, federal law requires states to contract with EQROs<sup>10</sup> for certain quality review functions, but some states contract with EQROs for additional quality review and data validation as well. Some Medicaid agencies work collaboratively with other state agencies, such as those responsible for health, aging, or disability services. All eight states involve consumers or consumer advocacy organizations in designing, monitoring, and evaluating overall program performance. Despite the additional time involved in contracting with vendors, developing interdepartmental agreements, and organizing consumer advisory committees, state Medicaid officials cited the following benefits from these partnerships:

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<sup>9</sup> Although not discussed during interviews with state officials, we recognize that state legislatures play an important role in oversight of MLTSS programs.

<sup>10</sup> Federal law defines an EQRO as an independent organization with demonstrated experience and knowledge of (1) Medicaid recipients, policies, data systems, and processes; (2) managed care delivery systems, organizations, and financing; (3) quality assessment and improvement methods; and (4) research design and methodology, including statistical analysis.

**EQROs.** States are required to contract with an EQRO to conduct an external quality review and independently validate (1) MCO performance improvement projects;<sup>11</sup> (2) MCO quality measures; and (3) MCO compliance with state structure, operations, access, and quality standards.<sup>12</sup> Five of the study states also contract with EQROs to perform optional activities. The most common of these activities is oversight of care management/care coordination (see table 2 for more detail).<sup>13</sup> In addition to providing an independent, objective review, EQROs often can enhance the state agency’s data analysis and research capabilities, improve the reliability of data, and ensure that quality assessments are performed fairly. For example, one state official said, “the EQRO can select a representative sample [of functional screens], and I’m not sure we did a scientific [random] sample before.” Contracting with an EQRO for extra functions can help states sustain oversight capacity regardless of changes in Medicaid staff. The states that do not contract with EQROs for any of the optional activities generally have in-house capacity to analyze plan encounter data and provide technical assistance to plans on quality improvement.

**Health, aging, and disability agencies.** Most of the states involve these agencies in their oversight activities in order to enhance oversight capacity and add expertise in LTSS issues. These agencies deliver a wide range of services that are relevant to MLTSS programs, including disease prevention/health promotion, nutritional assistance, support for family caregivers, training of direct care workers, protection of elder rights, and home and community-based services (HCBS) not covered by Medicaid. However, their role and level of involvement varies by state, often based on specific roles, strengths, and competencies of staff in the respective agencies.

In some states, these arrangements involve formal contracts or memorandums of understanding (MOUs). Minnesota’s Medicaid agency has an MOU with the state Department of Health’s (MDH) Managed Care Systems unit to license all managed care plans to perform specific oversight of Medicaid MLTSS plans. The MDH conducts regular examinations of MCOs to ensure that they comply with laws and rules governing financial solvency, quality of care, access to services, complaints, appeals, and other consumer rights. The MDH also conducts specialized audit functions on MLTSS care plans and requirements.<sup>14</sup> Because of the MDH expertise in quality review, the state contracts with an EQRO only for federally required functions. MDH in turn contracts with the Minnesota Department of Commerce to review managed care plans’ financial statements and compliance with reserve and loss ratio requirements.

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<sup>11</sup> As defined in 42 CFR §438.240, performance improvement projects (PIPs) use a continuous quality improvement model to identify quality problems, implement interventions to address them, evaluate the results, and develop systemwide changes to increase or sustain improvements. See the Quality Assurance and Improvement section of this report for more detail.

<sup>12</sup> 42 CFR § 438.354.

<sup>13</sup> As allowed by 42 CFR §438.356-8, states may contract with an EQRO for five optional quality review activities: (1) validating encounter data, (2) administering or validating consumer or provider surveys of quality of care, (3) calculating additional performance measures, (4) conducting additional performance improvement projects, and (5) conducting studies on quality that focus on a particular services. EQROs can also provide technical guidance to MCOs to assist them in providing the right data and information for the external quality review.

<sup>14</sup> See results from recent health plan examinations at <http://www.health.state.mn.us/divs/hpsc/mcs/quality.htm>.

Collaboration with state and local human service and aging agencies is common. In Texas, staff from the Department of Aging and Disability Services (DADS), located in regional offices, assists in on-the-ground monitoring of LTSS-related service coordination provided by STAR+PLUS plans. DADS also licenses health care organizations such as home health agencies with which MCOs contract.

Wisconsin's county human service agencies were given responsibility for developing local MLTSS programs, and over time many of them formed regional organizations covering many counties to contract with the Medicaid agency.

To manage the Massachusetts MLTSS program, Senior Care Options (SCO), Massachusetts Medicaid works closely with the state Executive Office of Elder Affairs, because state law requires all plans participating in SCO to contract with Aging Services Access Points (ASAPs), which are funded by Elder Affairs, for geriatric support service coordination.<sup>15</sup> The collaboration also gives SCO access to Elder Affairs staff expertise on adult protective services in cases of suspected abuse or neglect of SCO members.

Until recently, New Mexico's Medicaid agency shared operational responsibility for its MLTSS program, called Coordination of Long-Term Services (CoLTS), with the Aging & Long-Term Services Department (ALTSD). Before 2011, ALTSD was the operational agency for the CoLTS managed care program and performed certain LTSS quality assurance activities. In 2011, the state transferred approximately 12 ALTSD staff involved with CoLTS oversight to the Medicaid agency to streamline functions and reduce duplication in overseeing MCO performance. This move gives the Medicaid agency in-house knowledge of the service systems for each population, which helps in assessing provider network adequacy and provides in-house expertise on federal rules governing LTSS, such as 1915(c) quality assurance requirements.<sup>16</sup>

**Consumer groups.** All eight states engage members and consumer advocates in a variety of ways. Some conduct public forums to solicit input and feedback from consumers and the public on proposals to expand or make significant changes to existing MLTSS programs. Others convene consumer advisory groups on a regular basis or at critical decision points. As one state official observed, "This feedback ensures that any changes in program design will serve beneficiaries well." At least five states also use consumer feedback to refine contract requirements. For example, in one state, consumers reported problems getting access to transportation services, which led to changes in the transportation subcontract. Two other states concerned about allegations of abuse by

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<sup>15</sup> ASAPs in Massachusetts also perform eligibility screening for many LTSS programs. For more detail on the ASAP-SCO relationship, see B. Burwell, P. Saucier, and L. Walker, *Care Management Practices in Integrated Care Models for Dual Eligibles*, 2010-07 (Washington, DC: AARP Public Policy Institute, October 2010).

<sup>16</sup> In states where MLTSS plans are not statewide, or do not cover all older adults or people with disabilities, aging and disability agency staff often retain their traditional role in HCBS waiver administration, functional eligibility assessment, care coordination, quality assurance, and other activities for Medicaid beneficiaries not enrolled in MLTSS plans, and for those using state-funded HCBS. When these responsibilities are transferred to MCOs, the plans often hire former state and local aging and disability staff, who bring skill and knowledge in these functions. If MLTSS programs have limited risk for nursing home care, Medicaid staff must still be involved in NF/ICF-MR payment policy and licensing, survey, and quality assurance functions for institutions.

personal care workers convened consumer work groups to elicit suggestions on how to modify qualifications for personal care attendants in contract standards.

Because consumer feedback is important for MCOs as well as states, most states require MCOs to include consumers on advisory or governance boards, or on other types of informal committees. State officials monitor compliance with this obligation by requiring plans to submit agendas and meeting minutes, and on occasion, by attending the meetings in person.

Obtaining consumer feedback on a regular basis, and using it to improve program operations, can be challenging. One state reported that it receives a large volume of consumer feedback from advocacy groups and from three systems for complaints and grievances, making it difficult to sort out priorities and turn the information into systemwide improvements. Another state official described the challenge of keeping consumers involved: “We had an active [consumer group] for older adults, but attendance fell off over time . . . once [our program] expanded and became the usual way for people to get services, people got bored with the meetings.” Nonetheless, states generally affirmed the value of stakeholder feedback, and those whose consumer groups had lost momentum said that they hoped to reinvigorate the groups. States considering a shift from voluntary to mandatory enrollment regard consumer input as essential. As one state official said, “As we move toward a mandatory environment, consumers will play a larger role.”

**Vendors and consultants.** Because federal rules require states to have an independent actuary certify that capitation rates are actuarially sound, states contract with qualified actuaries to carry out this function. As discussed later, a few states, including Wisconsin, contract with external organizations to operate independent ombudsman services for MLTSS members. Each of these roles extends and strengthens program oversight by using people with recognized expertise.

### **The Role of Staff Skill Mix and Information Technology**

Medicaid agency staff bear the ultimate responsibility for combining information from all sources and using it to create a full picture of each plan’s performance and overall program progress. Consequently, we asked senior Medicaid officials about the role of staff qualifications and IT systems in effective monitoring of MLTSS contracts.

**Staff qualifications.** Having staff with the right qualifications is critical. State representatives identified the essential qualifications, or core competencies, for six key oversight functions (see table 3). For MLTSS programs in particular, program managers stress the importance of having people with clinical or managerial experience in LTSS delivery systems, HCBS quality assurance, and care management for older adults and people with disabilities. One state official emphasized the importance of having clinicians and other professionals involved in the development of appropriate MLTSS quality measures and in quality oversight. Another state official said that those who oversee MLTSS contracts “have to know about [HCBS] waivers and understand differences in service systems and emphases for each population.” But if such staff have had experience only in FFS or managed care delivery models that do not include LTSS, “we need to train them in how to monitor those services in a managed care system,” cautioned another state respondent.

**Table 3**  
**State Medicaid MLTSS Oversight Team Qualifications**

Oversight Roles	Qualifications and Specialized Knowledge, Skills, or Experience
<b>1. Program Direction and Management</b>	<ul style="list-style-type: none"> <li>▪ Understanding of the big picture: health policy, financing, rates, and analytics</li> <li>▪ Deep knowledge of managed care regulations and operations, and LTSS delivery systems</li> <li>▪ Contract and rate negotiation skills</li> <li>▪ For programs for dual enrollees, knowledge of Medicare policy and how it intersects with Medicaid benefits</li> </ul>
<b>2. Contract Development, Negotiation, Monitoring, and Enforcement</b>	<ul style="list-style-type: none"> <li>▪ Skill and experience in contract negotiation strategies</li> <li>▪ Knowledge of state procurement rules and procedures</li> <li>▪ Knowledge of all key managed care operations, from marketing and enrollment to provider contracting and member relations</li> <li>▪ Understanding of key contract monitoring and enforcement activities</li> <li>▪ Ability to use information tools to track plan progress against identified markers</li> </ul>
<b>3. Provider Network Adequacy/Access to Services</b>	<ul style="list-style-type: none"> <li>▪ Ability to use and/or interpret geographic mapping programs</li> <li>▪ Knowledge of provider licensing requirements</li> <li>▪ Ability to link consumer complaints to problems with access</li> <li>▪ Ability to work collaboratively with plans to address access issues</li> <li>▪ Knowledge of provider adequacy and accessibility for various populations in geographic areas</li> </ul>
<b>4. Quality Assurance/ Care Coordination</b>	<ul style="list-style-type: none"> <li>▪ Knowledge of 1915(b) and (c) waiver authorities</li> <li>▪ Knowledge of quality requirements in BBA regulations, Medicare rules, and NCQA accreditation requirements</li> <li>▪ Understanding of assessment, care planning, and care coordination processes, as well as LTSS generally</li> <li>▪ Provider-based or managerial experience in LTSS</li> </ul>
<b>5. Beneficiary Education, Rights, and Member Relations</b>	<ul style="list-style-type: none"> <li>▪ Experience working with consumer advocacy groups</li> <li>▪ Ability to forge consensus among groups</li> <li>▪ Understanding of member grievance and appeals rights and procedures</li> <li>▪ Experience with ombudsman programs and benefits counseling services</li> </ul>
<b>6. Rate Setting and Financial Oversight</b>	<ul style="list-style-type: none"> <li>▪ Understanding of accounting principles</li> <li>▪ Experience using case mix systems and risk adjustment tools</li> <li>▪ Understanding of data sources and database management</li> <li>▪ Statistical programming skills</li> </ul>

BBA = Balanced Budget Act of 1997; NCQA = National Committee for Quality Assurance

When states develop new MLTSS programs, the type and amount of training required to ensure that Medicaid staff can oversee such contracts (as distinct from managed care contracts covering children and adults without disabilities) depends on the state's experience with managed care contracting. States with a long history of managed care may already have qualified staff who need some additional training on LTSS issues. States switching from a predominantly FFS system to managed care may require completely new staff with contract negotiation and management skills, or else will require substantial retraining of existing staff. In either case, success depends on senior managers. Said one official, "You really need strong leaders to make the transition [from FFS to managed care] and to help bring other employees up to speed to do their job well."

**Use of information technology.** Data and information are essential tools in program operations, contract monitoring, and overall evaluation. As one program manager said, "This is a complex undertaking and your program will fail or succeed based on it [sophistication in the use of IT]." Operationally, IT systems are critical for determining eligibility of Medicaid beneficiaries for LTSS, facilitating enrollment and disenrollment in plans, tracking service authorization, and monitoring case management. Effective contract monitoring depends on robust IT systems that can track whether MCOs submit all required reports on time and can aggregate encounter data to monitor beneficiary service use, cost patterns, quality measures, and other performance indicators at the plan and program levels.



## CORE CAPACITIES FOR MONITORING MLTSS CONTRACTS

After focusing on critical inputs to effective MLTSS program oversight, we turn to a detailed examination of the activities that often consume the most resources—keeping watch over managed care plan compliance with contract terms and requirements. This section describes five major monitoring functions—referred to as core capacities—in which state Medicaid staff, contractors, and information systems are engaged:

1. **Contract Monitoring and Performance Improvement**—Ensuring MCO compliance with all contract requirements through regular communication with plan representatives, enforcement tools such as corrective action plans, penalties or sanctions for violations, and incentives to improve plan performance across a broad range of care quality, customer service, and provider-related measures over time.
2. **Provider Network Adequacy and Access to Services**—Ensuring that MCOs have sufficient numbers and types of health and LTSS providers (including care coordinators) to serve beneficiaries and that beneficiaries have timely access to care that is physically accessible, culturally competent, and available in languages spoken by significant numbers of enrollees.
3. **Quality Assurance and Improvement**—Ensuring that beneficiaries have access to providers and services that are of high quality, meet quality standards specified in contracts, are patient- and family-centered by respecting individual choices and preferences, and continually improve over time.
4. **Member Education and Consumer Rights**—Ensuring that beneficiaries understand the choice of plans, providers, and services available, enrollment and disenrollment procedures, and their legal right to receive full access to covered benefits. Ensuring consumers' rights to file grievances and appeals, and to have assistance in doing so, if they believe they have been wrongly denied covered services. (This core capacity also includes contingency plans for receipt of services during the appeals process. The entire domain needs to address issues related to cultural competency and language access.)
5. **Rate Setting**—Setting actuarially sound rates that pay program contractors appropriately to ensure financial stability and access to necessary services and providers.

While these monitoring functions are common among all states that operate Medicaid managed care programs, there are differences in how Medicaid agencies carry them out. State responsibilities for operating and monitoring Medicaid managed care programs are defined in federal regulations<sup>17</sup> and cover a range of issues, from protecting enrollee rights and setting actuarially sound capitation rates to ensuring care quality. But the federal rules give states some latitude in defining specific contract requirements and methods for monitoring plan compliance.<sup>18</sup>

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<sup>17</sup> 42 CFR §438.

<sup>18</sup> For example, Section 438.207 requires state Medicaid agencies to ensure, through contracts with MCOs, that plans have sufficient provider capacity to serve enrollees in their service area, but federal rules leave it to states to specify how many providers each plan must contract with to meet this requirement, how plans will verify that such providers are available to beneficiaries, and how frequently they review provider network adequacy.

We identified the types of activities states used to oversee Medicaid MLTSS plans in each core oversight function. We then compared these activities with the federal regulations to determine whether they were consistent with or went above or below federal standards. For activities not specified in federal regulations, we analyzed how common they were in the eight states, how often they were conducted, and what resources they required. We then classified state monitoring activities in each core oversight capacity into three groups:

- **Norms**—Oversight practices required by federal rules or used by most of the states.
- **Promising Practices**—Practices that go beyond federal regulations, may help to improve plan performance or beneficiary outcomes, and often involve more innovative or frequent review or require greater capacity or resources than are typical in most states. We do not call them “best practices” as there is not enough evidence to prove that they produce better outcomes.
- **Caution Flags**—Practices that may pose a risk to beneficiaries or to achieving program goals because they involve sporadic or cursory oversight and monitoring of plan performance, or do not use incentives or apply penalties.

Classifying monitoring practices in this way enables states to benchmark their efforts with those of other states to determine which capacities could be strengthened. The “Capacity Indicator” charts in this section show state activities in these three categories for four core monitoring capacities.<sup>19</sup> The charts list only those activities observed in or described by the study states.

### **Contract Monitoring and Performance Improvement**

Effective contract monitoring requires states to keep abreast of a broad spectrum of plan activities and performance indicators, including determining compliance with contract requirements regarding access to services, provider networks, care quality, beneficiary rights, and plan financial status. Consistent with the adage “you can’t manage what you can’t measure,” states require plans to submit numerous reports and data that help them measure compliance with access and quality requirements, assess progress toward performance targets, determine whether corrective actions are required, and inform an overall evaluation of the program (figure 3).

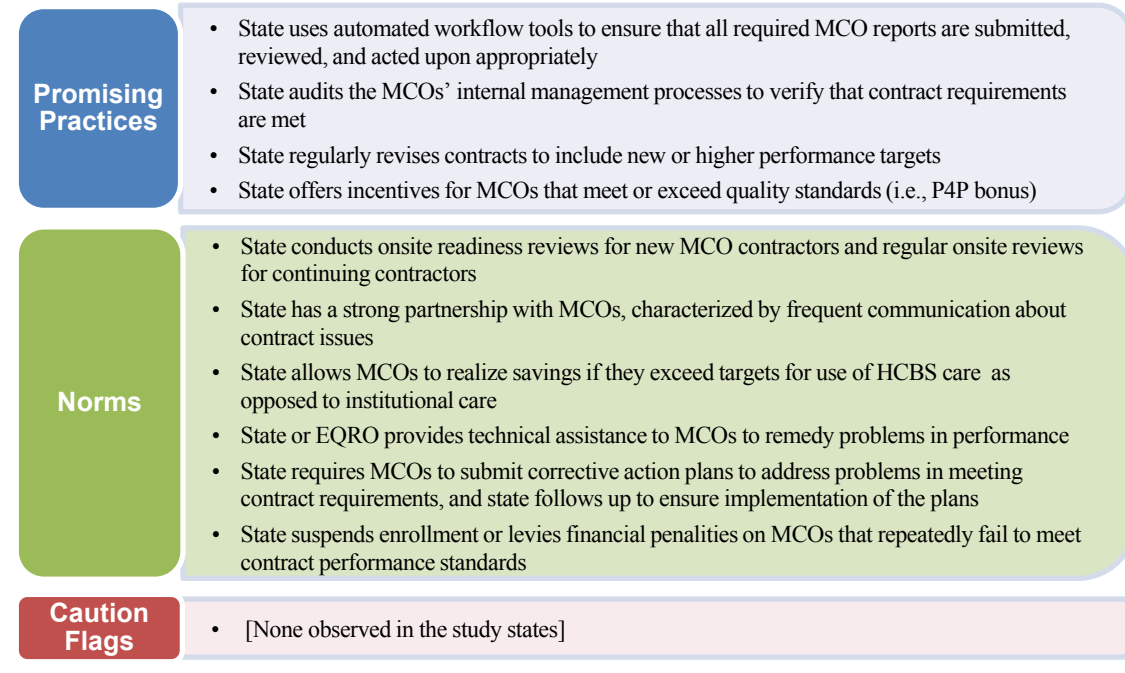
**Norms.** Most of the states conduct initial “readiness reviews” for any new managed care contractors to make sure they have the systems and capacity to comply with contract requirements. This is similar to the readiness assessment used by the Centers for Medicare and Medicaid Services (CMS)—the federal agency with authority over Medicare and Medicaid—to determine whether new Medicare Advantage (managed care plans) are able to comply with all program requirements. While Medicare Advantage plans complete the readiness assessment online, state-level readiness reviews typically involve a desk review of documents, as well as an onsite review at the plan’s facilities, and a systems review to make sure the plan systems are ready to pay providers. While

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<sup>19</sup> Due to the highly technical nature of the issues involved in the fifth core capacity (rate setting), this study did not examine state practices in depth.



**Figure 3**  
**Capacity Indicators: Contract Monitoring and Performance Improvement**



federal Medicaid law does not require states to conduct such reviews for new Medicaid MCOs, all of the states<sup>20</sup> in this study do so before enrollment begins.<sup>21</sup>

To promote compliance with contract terms, states typically try to develop strong partnerships with MCOs. Six states schedule regular meetings and other communication with MCO managers to discuss strategies for ensuring that MCOs can comply with contract requirements, and to improve plan performance over time. Tennessee described its collaborative approach: “[W]e believe in engaging our MCOs not just in a punitive manner. When there is a problem, we solve it together. We give [MCOs] a chance to be heard.” Communication occurs frequently, often daily, when a new MCO is first awarded a contract, and then usually tapers off to monthly or quarterly as operations stabilize. Four states facilitate communication by assigning a single contract manager to serve as the primary point of contact for each MCO and request that MCOs do the same. Some states make a point of contracting with plans that indicate, through language and examples provided in their bid, that they will be good partners and according to one state official are “not just looking for profit but focused on providing member-centered, good quality care.” States feel that this collaborative approach fosters the development of high-

<sup>20</sup> For example, the Texas STAR+PLUS Expansion contract describes the “Transitions Phase Requirements” (section 7) between a new MCO contract award and its operations start date, during which an organizational readiness review process occurs.  
<http://www.hhsc.state.tx.us/medicaid/STARPLUSExpansionContract.pdf>.

<sup>21</sup> The AARP Public Policy Institute is now studying how state Medicaid agencies in six states conduct MCO readiness reviews for managed care plans that will be providing MLTSS to vulnerable adults for the first time.

performing programs because “if plans feel like they’re part of the process, they’ll be more invested and will do a better job.”

States use a variety of tools to evaluate performance within and across plans. For plans that cover LTSS, states need measures that are specific to these services, but there are no national standards. As one program manager said, “We need standardized national measures for long-term care quality, something like the Healthcare Effectiveness Data and Information Set (HEDIS)<sup>22</sup> for long-term care that is applicable outside of Medicare Dual Special Needs Plan (D-SNP) model (which serve many dual-eligibles who do not use LTSS).”

In the absence of national standards, states use a variety of approaches and measures (explained in box 1). States whose MLTSS programs operate or formerly operated under 1915(c) HCBS waiver authority, such as Minnesota, Tennessee, Texas, and Wisconsin, assess LTSS access and quality in the same way they assess FFS HCBS waiver services—by assessing plan compliance in carrying out processes in six “sub-assurance” areas: (1) level of care determination, (2) service plan development and maintenance, (3) contracting with qualified providers, (4) ensuring beneficiary health and welfare, (5) using appropriate administrative authority, and (6) financial accountability procedures. For example, Texas uses 32 HCBS-related performance measures to assess STAR+PLUS plans’ LTSS quality. These measures include the number and percentage of members (1) whose service plans address their assessed needs, (2) whose service coordinator asked about their personal goals, (3) who receive all services in the care plan, and (4) who were allowed a choice of waiver services. STAR+PLUS enrollees are also surveyed annually by the EQRO about service use; experience; satisfaction with doctors, including specialists; and care coordination.

In addition, because many MLTSS programs seek to shift the balance of care from institutions to home and community-based settings, the states closely monitor the proportion of members in each setting. Four states also offer MCOs financial incentives to increase the proportion of clients in HCBS versus institutions (discussed below in Rate Setting).

States use a variety of techniques to remedy problems with plans that are not meeting performance targets or expectations. They provide technical assistance, sometimes through an EQRO.<sup>23</sup> They also require MCOs to submit corrective action plans that outline steps they will take to address problems in meeting contract requirements. “Having a corrective action in a plan’s record is very undesirable, so that motivates [MCOs]. We find this to be an effective strategy and a good way to get plans’ attention. Sometimes [the problem] is a technical issue and . . . finding a solution can take time.” Moreover, six states reported that they have suspended enrollment in a particular service area or levied financial penalties on MCOs that repeatedly fail to meet contract performance standards. These types of sanctions are frequently included in state contracts, and it is the norm for leading states to exercise them.

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<sup>22</sup> The Healthcare Effectiveness Data and Information Set (HEDIS) consists of 75 measures across eight domains of care: Effectiveness of Care, Access/Availability of Care, Satisfaction with the Experience of Care, Use of Services, Cost of Care, Health Plan Descriptive Information, Health Plan Stability, Informed Health Care Choices. For more information, see <http://www.ncqa.org/tabid/59/default.aspx>.

<sup>23</sup> An option available under 42 CFR §438.358.

### Box 1. LTSS Quality Performance Measures

Many people enrolled in MLTSS programs have multiple chronic health conditions that require regular medical attention. To measure the quality of acute and primary care, state Medicaid agencies can compare managed care plan performance against nationally recognized measures. These are drawn from two primary sources: (1) the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which include numerous clinical care indicators, and (2) the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which surveys plan members on how well doctors communicate, whether members can get care without long waits and get the care they need, health plan customer service, and overall satisfaction.

However, standardized measures of LTSS quality have not yet been developed, making it difficult for states and consumers to make “apples-to-apples” comparisons of plan performance on LTSS indicators. To address this gap, state Medicaid agencies have had to create their own LTSS measures. The study states rely mostly on structure or process measures such as the following:

- Percentage of members who receive HCBS based on a comprehensive care assessment and care plan, within 30 days of enrollment
- Share of members whose records confirm they that were asked about their care preferences
- Number of home safety evaluations
- Number of members over 75 years of age at risk for falls who have been asked at least annually about occurrence of falls and treated for related risks
- Proportion of single-bed nursing facility rooms out of total available (includes shared rooms)
- Nursing home readmissions within 30 days of discharge

A few states also track **functional outcomes**. For example, Wisconsin and Minnesota measure the share of program enrollees whose need for help with ADLs increases, decreases, or stays the same. Some states also conduct regular surveys of members to determine whether they receive person-centered care, such as the Participant Experience Survey, which many HCBS waiver programs use to assess quality of life. Wisconsin developed its own survey, called the Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES), to gather information about consumers’ personal outcomes, including whether they live in their preferred setting, are treated with respect, feel safe, and can decide on their own schedule. Minnesota adds supplemental questions to the CAHPS survey to ask how satisfied members are with their care coordination.

Appendix B shows the types of measures the states use to monitor the quality of care in (1) health care services, (2) LTSS, and (3) consumer experience and satisfaction with care. It also has links to state websites that publicly report these measures.

**Promising practices.** Three states review MCO compliance with submitting all required data and reports on schedule, either through sophisticated software tools or onsite audits of information systems. Tennessee, for example, monitors compliance with reporting requirements through the use of automated workflow tools, which track when MCO reports are submitted and ensure that they are reviewed and acted upon appropriately. In this system, “every MCO-required report has an ‘owner’— someone in the state who is responsible for reviewing it, and an associated process that describes what to do with it.” Minnesota and Wisconsin send oversight staff onsite annually to audit the MCOs’ information management system, among other things.<sup>24</sup>

Arizona, Minnesota, Tennessee, and Wisconsin regularly revise their contracts to include new or higher performance targets. While most states plan such changes to coincide with periodic contract renewals, during the rollout of its MLTSS contract, Tennessee’s CHOICES program used the contract revision process more frequently to fix problems that were not foreseen in the planning stage. For example, although Tennessee included very specific requirements in its contracts with MCOs, “[managed LTSS] was such a new system that we weren’t sure if we included too much or not enough, so if a report was not right, we changed it.”

Minnesota, Tennessee, Texas, and Wisconsin offer performance incentives or pay-for-performance bonuses to plans that meet or exceed quality standards. Tennessee’s Money Follows the Person program—a demonstration supporting state efforts to help people living in institutions transition back to home and community-based settings—pays MCOs \$2,000 for each person transitioned out of institutional care beyond a minimum target and \$5,000 if that person stays in the community for an entire year. In 2006, Wisconsin’s Family Care program distributed just over \$1 million in graduated incentive payments to MCOs that tested 75 percent of members for diabetes, reduced the share of members with poorly controlled diabetes, and/or improved the rate of preventable hospitalizations and emergency room visits.<sup>25</sup> In 2008, the state conducted a similar program related to dementia screening. Texas withholds 1 percent of the capitation payment and awards all or a portion of the funds to plans that meet performance targets. While performance incentives are useful tools, they are vulnerable to budget cuts during economic downturns. Two of the states that previously offered bonuses had to eliminate some of them due to state budget cuts.

**Caution flags.** Although the states engage in rigorous performance monitoring and improvement activities, three do not offer financial bonuses to MCOs that exceed state performance targets related to use of HCBS. This may impede the program’s ability to shift the balance of LTSS toward community-based care, but states have other tools, such as methods used to set capitation rates (discussed further in Rate Setting), to promote use of HCBS.

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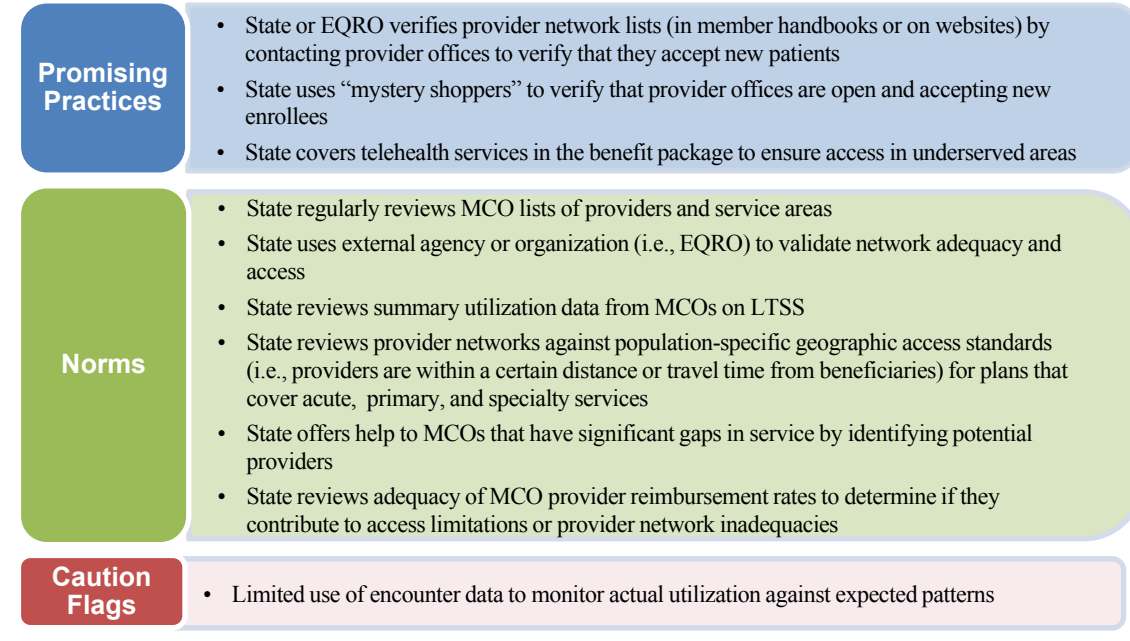
<sup>24</sup> For Minnesota’s other auditing and examination procedures, see <http://www.health.state.mn.us/divs/hpsc/mcs/quality.htm>.

<sup>25</sup> Wisconsin Department of Health Services, *Performance-Based Contracting in Family Care Background and Project*, <http://www.dhs.wisconsin.gov/lcure/StateFedReqs/p4p.pdf>.

## Provider Network Adequacy and Access to Services

Federal rules require states to ensure that MCOs maintain adequate provider networks<sup>26</sup> so that beneficiaries will have access to the care they need. Because older adults and people with disabilities have a diverse set of health and disabling conditions, MCOs must contract with a broad range of providers, from primary care doctors and specialists to home care and behavioral health providers. In addition, people with different types of disability require that providers be physically accessible and be able to communicate effectively with them. Providers also must accept new clients, hold appointments during times that are convenient for clients, make their services culturally and linguistically accessible, and be located within a reasonable travel distance from the populations they serve. Ensuring access to HCBS is especially critical for older adults and people with disabilities who rely on personal care workers to help them with ADLs, including getting up in the morning, bathing, toileting, dressing, and eating (see figure 4).

**Figure 4**  
Capacity Indicators: Provider Network Adequacy and Access to Services



All the states either allow or require one or more MCOs to offer consumer-directed options to beneficiaries with certain disabilities, either by employing the care attendants they choose (often family members) or by receiving a cash allowance to spend on services of their choice. This study did not assess differences in state Medicaid capacities or approaches to monitoring consumer-directed compared to plan-directed care. Because consumer-directed models allow family members to provide services, they may require different monitoring activities, but this study did not investigate this topic.

<sup>26</sup> 42 CFR §438.207.

**Norms.** Federal rules require states to certify to CMS that providers contracting with MCOs meet state access and network standards for timely access to care.<sup>27</sup> Even though federal regulations do not explicitly define *how* states should monitor the adequacy of provider networks, most states conduct similar activities that have become the norm. For example, seven states regularly review the list of providers and service areas that MCOs submit to them—quarterly, annually, or when major changes occur. They then compare these provider networks against the state’s population-specific geographic access standards (i.e., whether providers are within a certain distance or travel time from the beneficiaries they will serve).

To monitor LTSS access, states are required to collect and review summary utilization data from MCOs,<sup>28</sup> though there is some flexibility in the data or measures they collect. For example, two states require MCOs to track and report the number of personal care visits that are more than 30 minutes past due. Though federal regulations allow states to validate provider networks themselves, four states contract with EQROs to validate network adequacy and access, often in addition to the state’s own review activities.<sup>29</sup> In addition, four states review provider reimbursement rates to determine whether they promote or limit access to providers.<sup>30</sup> Five states offer to help MCOs fill network gaps by identifying potential providers. For example, because many social day care programs with which plans contracted were closing because of the recession, one state helped MCOs identify organizations that were still accepting new clients. MCOs have the flexibility to offer benefits that may not be covered in HCBS waiver programs. One state program manager cited an example of how this model can better meet each individual’s needs: “MCOs don’t put strict limits on home modification costs.”

**Promising practices.** Some approaches to verifying or supplementing provider networks involve extra steps to ensure that all providers on network lists are actually available and accessible, and use the beneficiaries’ perspective to monitor access. Wisconsin explained that “when we started [reviewing managed care networks], we had all of our MCOs submit a spreadsheet with information about every provider offering a benefit in the package, who do they serve, are they accessible, etc. We continue to review these documents carefully. [But] now we also look at the provider lists that the MCOs post on their [member] website, to make sure they have adequate [providers], and we look at scope, geographic spread, access, etc.” Tennessee and Texas use “mystery shoppers” to call physicians and other professionals who are listed as network providers and verify that their offices are open and accepting new Medicaid clients. New Mexico supplements provider networks in underserved areas by covering telehealth services in the standard benefit package: “We are a big state and telehealth can be a very useful tool for making sure services are available in rural areas. Telehealth is very useful for services like behavioral health.”

**Caution flags.** For many states, encounter data (i.e., records of the health care services for which MCOs pay at the individual level) are an essential tool for monitoring patterns of service use. These data enable states to check the accuracy of summary

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<sup>27</sup> Ibid.

<sup>28</sup> 42 CFR §438.240.

<sup>29</sup> An option specified in 42 CFR §438.358.

<sup>30</sup> In accordance with 42 CFR §438.6.



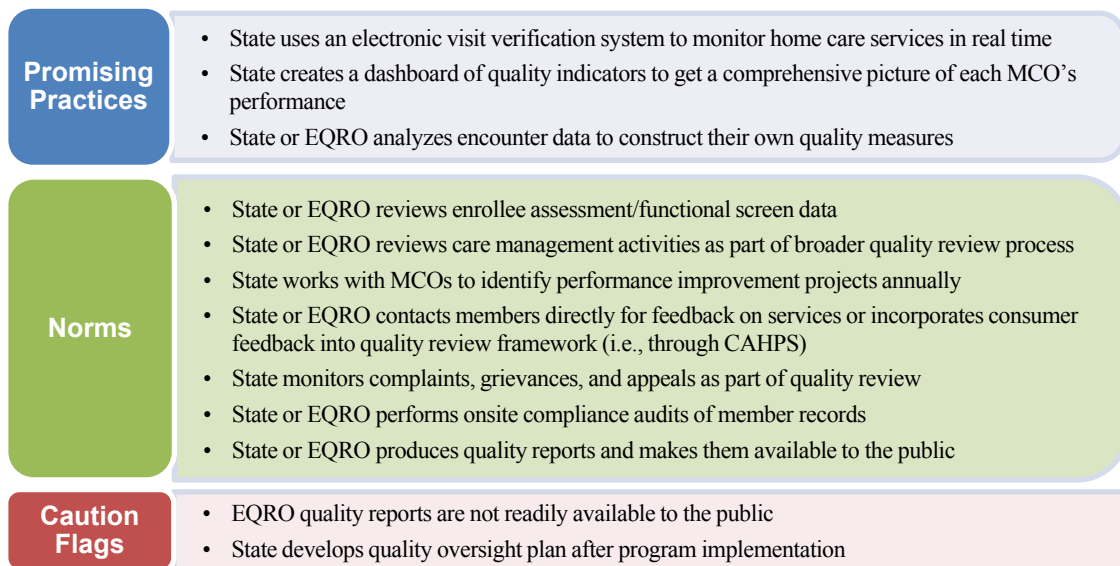
utilization measures reported by plans and can provide additional detail on population or geographic-specific utilization. One state has not yet been able to collect accurate encounter data from all plans. This raises a caution flag because, without reliable encounter data, the ability to monitor the adequacy of provider networks and access to services is limited. However, the state was planning to collect these data from all plans starting in fiscal year 2012.

### Quality Assurance and Improvement

Access to services does not guarantee beneficiaries high-quality care and improved quality of life. States should also ensure that providers are licensed, consumers have a choice of providers, care plans are person- and family-centered, and services are of high quality, meaning that they meet professional standards and the Institute of Medicine’s definition of quality: safe, effective, patient-centered, timely, efficient, and equitable.<sup>31</sup> By regularly assessing the degree to which services meet standard measures of quality, states can (1) monitor compliance with minimum standards specified in contracts, (2) assess progress toward goals overall and by plan, (3) determine priorities for quality improvement projects, and (4) know which penalties and incentives are working to improve the quality of care (figure 5).

**Norms.** Because of the importance of care management (referred to as care coordination by many states) to older adults and people with disabilities, all eight states require Medicaid managed care plans covering LTSS to provide this service to members. All states require MCOs to conduct a comprehensive initial assessment or functional screen to determine each enrollee’s level of care and service needs, which provides a baseline against which states can measure and monitor subsequent service use. For example, Wisconsin’s EQRO “pulls a sample of [member] service plans in each MCO...to verify that those services are being delivered. They also verify that the LTSS are delivered as specified in the care plans, and in accordance with the care assessment.”

**Figure 5**  
Capacity Indicators: Quality Assurance and Improvement



Though states use a variety of approaches to monitor care management (see box 2 for details), most feel that, because of the many services that care management touches, ensuring that it is provided on time and in accordance with the beneficiaries' needs helps ensure the overall quality of the MLTSS program.

Federal law requires MCOs to conduct one or more annual performance improvement projects (PIPs), which use a continuous quality improvement model to identify quality problems, implement interventions to address them, evaluate the results, and develop systemwide changes to increase or sustain improvements.<sup>32</sup> States may also use EQROs to validate the PIPs. Rather than allow each MCO to select its own PIPs, at least three states develop statewide priorities on which all MCOs must focus. Massachusetts describes how its PIPs fit into overall agency goals related to quality: “[Our agency has] five quality goals, and MCOs can each pick two [performance improvement] projects that fall under one of these goal areas. Based on our goals and their projects, we set performance targets and let the plans figure out how their projects will meet the targets. [PIPs were] a challenge in the beginning, but they became helpful. Every year plans submit more thoughtful projects. Some initiatives change from year to year but most plans have stuck with at least one initiative [and have improved upon it year after year].” While state program officials generally felt that PIPs are worthwhile, they caution that without incentives or penalties tied to their outcomes, PIPs may not yield significant improvements.

Seven states monitor quality by asking a sample of members directly about their care experiences by using either CAHPS surveys<sup>33</sup> or other consumer satisfaction surveys. The frequency of administering the survey varies, sometimes depending on how long the MCO has contracted with the state (e.g., every year for newer MCOs, every other year for experienced MCOs). States also look for patterns and trends in the types of complaints, grievances, and appeals from beneficiaries and other stakeholders to monitor quality of care. According to one state program manager, complaints are “one of the earliest indicators that there’s a gap in services. We find that if there’s a systematic problem, complaints start coming in from patients, from providers, and from advocacy groups, all at the same time.” Another state said it devotes significant resources to this function and described having “an entire office that keeps data, manages grievances, and if there are trends, reports back.”

In addition to seeking information directly from beneficiaries, six states or their EQROs audit member records maintained onsite at the MCO or by contracted providers, giving them a firsthand opportunity to review plan performance.<sup>34</sup> One state explained that it targets its onsite review by “going specifically to plans where we think there may be issues. [Our onsite review] provides another angle to our understanding of what is going on with these programs, [and gives us] human surveillance information in addition

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<sup>32</sup> 42 CFR §438.240.

<sup>33</sup> For further information about CAHPS, see <http://www.cahps.ahrq.gov/>.

<sup>34</sup> Some states also review MCO audits of their contracting providers. These reviews can give state officials more in-depth information about the quality and performance of contracted providers, and health plans may use state findings to improve their own coordination and management of LTSS.



## **Box 2. State Oversight of Care Management in Managed Care Plans Covering LTSS**

**Care management is a critical feature of managed care plans covering LTSS.** People with chronic illness or disabilities use many types of health care services, as well as LTSS. To ensure that consumers receive the services they need, when they need them, in settings they choose, managed care programs that cover LTSS employ care managers.

**Care management has common elements.** Care managers are often the consumer's primary point of contact for navigating the care system. They conduct an initial needs assessment and create an individualized care plan with clients, and where appropriate, their family members. They facilitate access to needed services by making sure care is provided on time and according to the care plan. They are knowledgeable about the range of benefits across the range of payers (including Medicare and Medicaid). Care managers may also work with family caregivers or connect clients to community services not covered by the managed care plan (e.g., by letting clients know where their Social Security office is, helping them obtain food stamps). Throughout the cycle of care, they communicate with the client and family and monitor progress through regular contact, either in person or by phone. Care managers often follow clients through care transitions (e.g., from the hospital to the nursing home and home again), serving as a valuable source of information and support to clients and their families along the way.

**States play an important role in overseeing care management.** CMS requires specific and frequent monitoring of HCBS provided under 1915(c) waivers. Because many state managed care programs that cover LTSS operate under this waiver authority, state Medicaid agencies must follow the same procedures to monitor HCBS provision and care coordination in FFS models and managed care plans. When managed care plans cover acute, primary, and specialty services, as well as LTSS, care management encompasses all of these services, and states can use care management oversight to ensure coordination across the care continuum. Monitoring care management can also help identify problems throughout the system that create barriers to care, such as gaps in provider networks, inaccessible sites of care, poor-quality services, need for specific benefit counseling, or breach of consumer rights. For example, Arizona pays close attention to care coordination because it helps to identify “systemic problem(s) that need bigger corrective action. Sometimes it’s just one member and we have to reeducate the case manager, but sometimes we find that all case managers misunderstood [our requirements] ... [so] we clarify our policy [to convey the original intent].”

**All eight states oversee care management.** Typical activities include the following:

- **Describing procedures that care managers must follow.** Some states are very prescriptive and include specific procedural requirements in plan contracts, such as ratios of care managers to clients. Arizona, for example, specifies responsibilities and qualifications of care managers, caseloads and assignments, availability of supervision, training, and maximum periods to contact new clients and make home visits.
- **Reviewing utilization and individual care plans.** States or their EQROs often select a random or representative sample of clients, or client records, to assess whether home visits and comprehensive assessments occur on schedule. Several review and audit plan records onsite.

- **Reviewing care manager training materials.** Because care managers are often the first point of information for a client, Arizona and Minnesota audit the MCOs' training materials to ensure that the guidance given to care managers is consistent with state standards and policies and includes any new or recently revised policies.
- **Surveying a sample of clients by telephone.** Client surveys help ensure that care managers are visiting clients, especially newly enrolled ones, within the required timeframe and on the required schedule. The EQRO or external partner frequently performs this review. Arizona surveys members by telephone because “everything in the file may look like it’s going great, but then you call the member and they say it’s not, or that the care manager hasn’t gotten back to them. [Speaking to clients] tells us so many more things.”

to data.” States use this information to supplement and produce quality reports, many of which are made available to the public (see appendix B for details).<sup>35</sup>

**Promising practices.** Real-time monitoring of service delivery through the use of new technology offers a more powerful tool than retrospective evaluation for assessing

certain aspects of quality. Tennessee and Texas both use electronic visit verification (EVV) systems to monitor home care services in real time. EVV systems require home care workers to electronically check in when they arrive at a client’s house and check out when they leave. The workers also must record the services provided during the visit. If the timing or services do not align with the individual’s service plan, care coordinators at the MCO are instantly notified and can reschedule the visit or find a replacement provider. The MCOs also use EVV data to create claims and to construct state oversight measures and reports. Tennessee described the introduction of the EVV system as “painful [at first], but now everyone agrees that it adds value and needs to be there. One of the MCOs in our state is thinking about employing it for the care they provide in other states.”

Arizona and Texas review a comprehensive set of quality indicators across plans, which they call a “dashboard.” This gives them a full picture of each MCO’s performance. Arizona staff hold quarterly meetings to review the complete set of indicators. “At quarterly all-staff meetings, [we] review reports, performance measures and key indicators. All the information reported by MCOs is compiled in one place, and reviewed by the entire team . . . from all units: quality, medical management, finance, claims and encounters. We can tell whether a plan is doing poorly in a specific area or in a number of areas, over time or at a single point of time, and [we] look at how changes in one area might affect changes in another, brainstorm solutions, look for trends and discuss potential compliance actions.”

Although all states are required to collect encounter data from plans, some states make better use of these data than others to monitor quality of care. Minnesota, for example, uses encounter data not just to set capitation rates and risk adjustors but also to evaluate MCO performance on HEDIS and other quality measures, and to develop detailed reports on service use and cost for its contracted MCOs, which are made available to the public. This encourages plans to submit high-quality data, since MCOs

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<sup>35</sup> As required by §438.240.

that do not submit good data may not receive appropriate rates, be able to prove they meet quality benchmarks, or be portrayed accurately in publicly released reports.<sup>36</sup>

**Caution flags.** Federal rules require states to make information and results from EQRO quality reviews available to the public on request, as long as patient confidentiality is protected.<sup>37</sup> One state shares EQRO quality review reports with MCOs but does not make the results readily available on state websites. One reason a state may not report this information publicly is that it may have problems accurately adjusting the quality measures to reflect the health and demographic characteristics of each plan's members, so the measures are not comparable. But unless states make quality review results publicly available, consumers, providers, and other stakeholders cannot easily compare MCO plan performance. In addition, one state started its program before systems were in place to measure care quality, and later found quality issues that should have been caught earlier. These examples underscore the need for states to plan how to construct, use, and report on quality measures early on.

### Member Education and Consumer Rights

Federal rules guarantee in managed care plan members numerous rights, including the right to receive information on plan options and benefits, enrollment and disenrollment procedures, and available treatment options and alternatives, and to participate in decisions regarding their services.<sup>38</sup> Members also have the right to file grievances and appeals if they believe they have been unfairly denied covered benefits or access to services.<sup>39</sup> MCOs play a central role in providing this information to members and their family members, and in organizing a grievance and appeals system. Therefore, states should ensure that MCOs are providing information that is accurate, accessible, and culturally and linguistically appropriate, and that the grievance and appeals system protects enrollee rights. Ensuring that older adults and people with disabilities receive appropriate information can require accommodations to address vision, hearing, or other impairments and varying levels of literacy (figure 6).

**Norms.** As required by federal rules,<sup>40</sup> the states provide member education and guarantee consumer rights in several ways. They carefully review member handbooks and other MCO documents for consistency with federal and state policies. They also review and approve MCOs' marketing and member education materials to ensure that they are clear and accessible to all members.<sup>41</sup> When LTSS benefits are offered in addition to acute, primary, and specialty care, states frequently provide integrated educational materials that explain all services and benefits in one place.

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<sup>36</sup> Vivian L. H. Byrd and James Verdier, "Collecting, Using, and Reporting Medicaid Encounter Data: A Primer for States," Final Report submitted to the Centers for Medicare and Medicaid Services (Mathematica Policy Research, October 19, 2011), [http://www.cms.gov/MedicaidDataSourcesGenInfo/17\\_TechnicalAssistance.asp](http://www.cms.gov/MedicaidDataSourcesGenInfo/17_TechnicalAssistance.asp).

<sup>37</sup> 42 CFR §438.364.

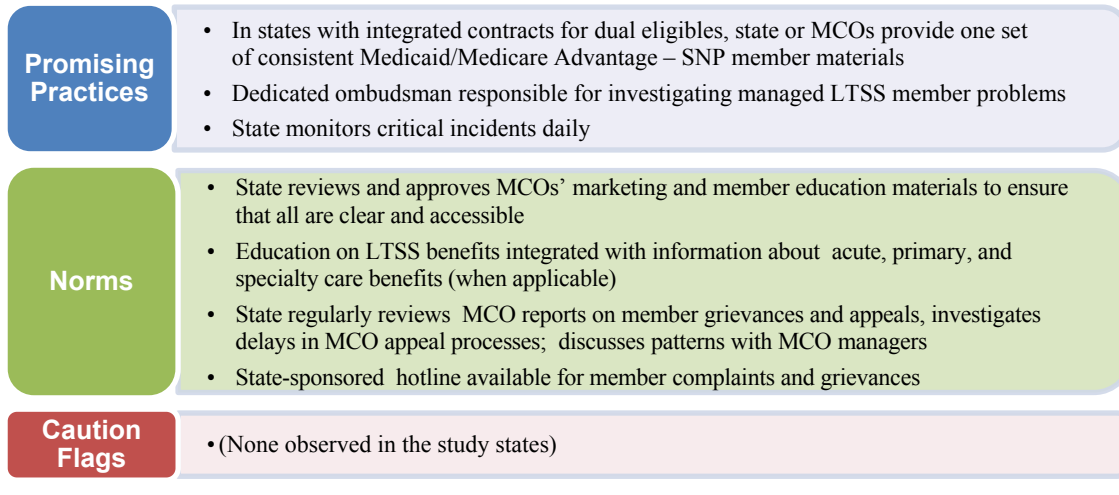
<sup>38</sup> 42 CFR 438.100.

<sup>39</sup> 42 CFR § 438.402.

<sup>40</sup> 42 CFR §438.10.

<sup>41</sup> As required by 42 CFR §438.206.

**Figure 6**  
**Capacity Indicators: Member Education and Consumer Rights**



Federal law requires MCOs to administer a system for members to file grievances and appeals,<sup>42</sup> and all states are required to review MCO reports on the frequency and nature of grievances filed, as well as the steps MCOs take to remedy such grievances. States must also provide an opportunity for a fair hearing to members whose grievance or appeal claims are denied or not acted upon promptly.<sup>43</sup> Because patterns in grievances and appeals provide a window into the overall program experience, states frequently discuss these patterns with MCO managers as they work to improve performance.

To complement the formal grievance and appeal system, four states sponsor hotlines to register complaints from consumers and providers on matters that are not subject to grievance and appeals. Hotlines provide additional insight into issues relating to member rights.

**Promising practices.** Several states provide more streamlined education materials or include additional actors to field and resolve grievances. Massachusetts, Minnesota, and Wisconsin, which have programs that integrate Medicaid and Medicare benefits for dual eligibles, provide a single set of consistent Medicaid and Medicare member materials, and grievance and appeal procedures. They often follow the guidance of Medicare Advantage-Special Needs Plans (MA-SNPs), which include both Medicare *and* Medicaid coverage in a single coordinated benefit package. Wisconsin engages its Aging and Disability Resource Centers (ADRCs)<sup>44</sup> to provide beneficiaries with a “one-stop shop” for information and advice on the health and social service options available to them, and to help resolve conflicts between members and their MCOs. When members are unhappy with their managed care services, ADRCs mediate between them and the MCO to help

<sup>42</sup> 42 CFR §438.228 and §438.402

<sup>43</sup> 42 CFR §431.205.

<sup>44</sup> ADRCs serve as single points of entry into the LTSS system for older adults and people with disabilities by providing objective information, advice, counseling, and assistance to support informed decisions about long-term options and help people access public and private LTSS programs. More information is available at [http://www.adrc-tae.org/tiki-index.php?page\\_ref\\_id=1325](http://www.adrc-tae.org/tiki-index.php?page_ref_id=1325).

solve conflicts before they result in disenrollment from a plan. Though Wisconsin's managed care programs are voluntary, they have high enrollment and retention rates, which the state attributes to the role of ADRCs in educating beneficiaries and managing grievances.<sup>45</sup>

Minnesota and Wisconsin supplement the mandatory grievance, appeals, and fair hearing processes by operating special ombudsman programs, whose staff are dedicated to investigating MLTSS member problems. New Mexico and Texas supplement the grievance and appeals system by reviewing daily reports of critical incidents of alleged abuse, neglect, or exploitation submitted by the plans. Because these incidents are egregious violations of member rights and personal welfare, frequent review provides the state with a real-time check on member welfare.

**Caution flags.** None of the states engaged in practices raising a caution flag. States that are just beginning to implement MLTSS programs should bear in mind that failing to provide clear member education materials or to ensure member rights can put members at risk of receiving inappropriate care. Therefore, the lack of a hotline to report grievances to the state; member education materials that are not available in a language that the beneficiary can understand; or the infrequent review of incidents of alleged abuse, neglect, or exploitation could be considered caution flags.

## Rate Setting

Paying MCOs adequate monthly capitation rates, adjusted for members' health and functional levels, is critical to the success of MLTSS programs. These rates should be set at levels that pay the "right amount" (enough but not too much) to reduce the risk that MCOs will deny needed care to beneficiaries.<sup>46</sup> If states do not set adequate payment rates, MCOs that enroll members with more serious health problems will be at greater risk of insolvency, so they will try to avoid enrolling members with greater health problems or greater need for daily assistance. If rates are not adequate, plans may pay low rates to providers, who may then withdraw from plan networks. As a result, members are more likely to have restricted access to services and providers. Rate-setting methods can also provide incentives for balancing the LTSS system from its traditional reliance on institutional care to greater use of HCBS—a key goal of MLTSS programs among the eight study states.

Setting rates that strike this balance is a highly technical and complex activity. This study did not include an in-depth investigation of state rate-setting practices; therefore, we do not derive promising practices, norms, or caution flags. Instead, we draw upon relevant literature to discuss common activities related to setting rates and the use of financial incentives to change the balance between institutional and home and community-based care.

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<sup>45</sup> Donna McDowell, "Managing Care in Wisconsin," presentation at the National Academy for State Health Policy Conference, Kansas City, MO, October 4, 2011.

<sup>46</sup> Richard Kronick and Karen Llanos, *Rate Setting for Medicaid Managed Long-Term Supports and Services: Best Practices and Recommendations for States* (Princeton, NJ: Center for Health Care Strategies, March 2008).

The rate-setting process relies on a significant amount of data on costs, utilization, and health and functional status. States use a variety of approaches to ensure that high-quality data are used to develop rates. On the front end, states edit encounter data to check for and remove inconsistencies and enforce data-reporting requirements for MCOs. They reconcile plan-reported data with other data sources, such as plan financial reports, and check for internal consistency and completeness. States also conduct in-depth audits or reviews, sometimes with the help of EQROs, actuaries, and other state agencies, to identify and address data reliability issues.<sup>47</sup>

Most states then use these data to set the initial base rate for beneficiaries eligible for MLTSS programs based on the FFS cost and utilization experience of beneficiaries in HCBS waiver programs. In subsequent years, states update the base rate either by applying a trend factor or by analyzing more recent data on beneficiaries, including those enrolled in HCBS programs and nursing facilities, if they are covered. States also risk adjust the rates to account for service need and setting; because high-need beneficiaries will require more costly care, states make higher payments to plans in which these individuals are enrolled. Of the nine states profiled in a recent report (Kronick and Llanos 2008),<sup>48</sup> two—Florida and Wisconsin—make individual-level payment adjustments based on functional or health status of each enrollee. Three others—Arizona, New York, and Tennessee—use a rate process that pays more to MCOs that serve a disproportionate number of high-need members.

States vary in the extent to which they use rate setting to create incentives for plans to serve beneficiaries in community versus institutional settings. Some program managers believe that the strongest incentives require MCOs to be fully responsible for nursing facility care and do not adjust their payment when a beneficiary first enters a nursing facility (though in subsequent years, capitated rates may be adjusted to reflect nursing facility admissions among plan members). Arizona explains that “[a single rate] means it’s really important for the state to feel comfortable that the rate appropriately reflects an accurate mix of HCBS and institutional services. We watch and monitor costs and utilization on a monthly basis, and we continue to push MCOs to serve more beneficiaries in HCBS than in nursing facilities.”<sup>49</sup> Tennessee, like Arizona, sets capitation rates based on a target for shifting the balance of care from institutions to home and community-based settings. Tennessee set an initial capitation rate that assumed 4 to 6 percent of new enrollees could be diverted from institutional care to HCBS use over two years; rates varied by region depending on the current mix of members and historical new enrollment in nursing facilities compared to HCBS.

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<sup>47</sup> U.S. Government Accountability Office, *Medicaid Managed Care: CMS’ Oversight of States’ Rate Setting Needs Improvement*. Report to Congressional Committees (August 2010).

<sup>48</sup> The states profiled were Arizona, California, Florida, Massachusetts, Minnesota, New York, Texas, Washington, and Wisconsin. Among the nine states in this study, New Mexico and Tennessee were not included because their MLTSS programs were not operational at that time. We added supplemental information from Tennessee that was gathered through e-mail communication with state officials.

<sup>49</sup> Kronick and Llanos, 2008



In the Texas STAR+PLUS program, nursing facility services were excluded from MCO covered benefits due to opposition by the nursing home industry.<sup>50</sup> But as an incentive for MCOs to keep nursing home admissions low, Texas withholds 5 percent of the premium from STAR+PLUS MCOs, which the MCOs can earn back if they meet performance standards on several measures, including no statistically significant increase in the nursing facility admission rate.<sup>51</sup> Massachusetts's SCO program covers institutional care, but if a member enters a nursing home, the plan receives the community capitation rate for 90 days, instead of the higher institutional rate. As an incentive to help members return home, Massachusetts pays SCO plans at the higher institutional care rate for the first three months after the member returns to a community-based setting. Minnesota limits MCO risk for nursing facility care to 180 days, but after a community-dwelling member eligible for nursing home care is admitted to a nursing home for more than 30 days, the plan loses an extra add-on to its regular capitation rate for the member. This gives MCOs an incentive to help members leave nursing homes as quickly as possible.

### **Summary: How State Oversight Can Improve LTSS System Performance**

This section discussed state Medicaid MLTSS oversight activities in five separate capacity domains, but they must work in concert to improve plan performance and achieve overall program goals. Indeed, there are encouraging signs that when states effectively coordinate oversight activities, they can achieve measurable improvements in quality of care and system rebalancing.

Arizona's Long Term Care System (ALTCS), the nation's longest-running MLTSS program, illustrates the pathways from state oversight practices to improved beneficiary and system outcomes. The Arizona Health Care Cost Containment System (AHCCCS), the state Medicaid agency, closely monitors its contracted plans, makes effective use of encounter data to create performance measures, and raises standards over time. As explained earlier, the agency creates a dashboard of key performance indicators to examine whether plans are having problems meeting standards in one or more areas and whether the problems are specific to one plan or common to all plans. If any plan's performance is below minimum standards, AHCCCS imposes corrective action plans. AHCCCS works in partnership with MCOs to identify ways to improve performance, but has also been willing to deny contract renewals to plans that consistently underperform.

Improvements in diabetes care among ALTCS members illustrate how state oversight practices contribute to plan performance. For many years, Arizona has regularly measured indicators of care for members with diabetes, one of which is testing of hemoglobin A1c (a blood glucose level test that indicates the effectiveness of measures to control diabetes). If plans had indicators below minimum state standards, the state imposed corrective action plans. In 2010, the overall rate of hemoglobin A1c testing was

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<sup>50</sup> Alice Lind, Suzanne Gore, Lindsay P. Barnette, and Stephen A. Somers, "Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services," Center for Health Care Strategies, November 2010.

<sup>51</sup> See Chapter 6.2.1 and 6.2.2 of the Texas Health and Human Services Commission Uniform Managed Care Manual at <http://www.hhsc.state.tx.us/medicaid/UMCM/default.html>. In February 2012, the publicly available version (dated January 1, 2011) cited 1 percent withholding, but Texas officials said that withholding increased to 5 percent in 2012.

77.8 percent across all ALTCS plans, significantly lower than the previous year's rate of 86.5 percent. But among the four plans continuing as contractors for 2012 (four others stopped participating as of 2012), the overall performance rate was 87.1 percent, higher than the previous year and above the state minimum standard (80 percent), as well as the HEDIS national Medicaid mean (82 percent).<sup>52</sup> The combination of regular measurement and imposition of corrective action plans was an important contributor to this improvement.

The state in this study with the newest MLTSS program—Tennessee—illustrates how coordinated state oversight activities can help to achieve rapid balancing of a state's LTSS system away from costly institutional care toward HCBS. The state worked closely with existing managed care plan contractors to design the program, established specific requirements concerning care coordination, and set capitation rates that assumed MCOs would be able to reduce institutional care by 4 to 6 percent over two years, depending on the region and enrollment changes. Program managers cite preliminary data indicating progress in LTSS system balancing: "Before the program began [in 2010], 17 percent of the long-term care population was using HCBS and the rest were in institutions. A little more than a year after statewide implementation, the ratio is a little more than 30 percent HCBS users of total LTSS users." This suggests the potential of MLTSS programs to rapidly balance LTSS systems, at least in a state with a low share of HCBS relative to total LTSS use at the start of the program.

Other factors, such as awarding contracts through competitive bids, may have contributed to these results, but these examples illustrate the potential of MLTSS program management and oversight to improve beneficiary outcomes and system balancing by (1) developing RFPs that set high standards for participating plans, (2) contracting with plans that demonstrate their ability to meet these standards; (3) establishing appropriate capitation rates and creating financial incentives for MCOs to exceed minimum performance thresholds, (4) applying penalties or corrective actions for MCOs that do not meet minimum standards; and (5) working in partnership with plans to improve performance and raise minimum standards over time.

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<sup>52</sup> AHCCCS, *Arizona Long Term Care System Performance Measure for Diabetes Care, Oct. 1, 2009–Sept. 30, 2010* (November 2011), [http://www.azahcccs.gov/reporting/Downloads/PerformanceMeasures/altcs/DiabetesReport\\_2011.pdf](http://www.azahcccs.gov/reporting/Downloads/PerformanceMeasures/altcs/DiabetesReport_2011.pdf).



## STATE READINESS TO IMPLEMENT NEW MLTSS PROGRAMS

States that have not operated MLTSS programs before may find it difficult at the outset to put in place the organizational models and norms in oversight functions that are practiced in experienced states. This raises two questions: Which oversight capacities are critical for state Medicaid agencies to have in place before contracts are signed and beneficiaries begin to enroll in plans? What can states do during program planning to make their oversight responsibilities more manageable and effective?

This section discusses the capacities that states planning new MLTSS programs need in order to ensure smooth implementation and increase the likelihood of achieving program goals. It is designed as a checklist to help assess whether state Medicaid agencies are ready to monitor care delivery and protect consumer rights on “day one” when plans begin enrolling members. The lessons draw on the experience and insights of current program managers and of “veteran” state officials who have played major roles in planning and implementing early generation MLTSS programs. They were asked to rank the importance of two types of issues associated with successful implementation: (1) program features and plan requirements that should be incorporated into RFPs soliciting bids from MCOs, and (2) state oversight functions and capacities that should be in place before day one. They identified six prerequisites that are critical or very useful to Medicaid agencies:

- Establish program goals that are supported by key stakeholders.
- Clearly communicate expectations and requirements to contracting organizations.
- Develop and sign contracts that spell out plan requirements and capitation rates.
- Hire qualified staff or contract with organizations that have knowledge of and experience working in LTSS programs and with managed care.
- Develop and test IT systems that can monitor the following on day one: provider network adequacy and access, quality assurance, consumer education and protection of member rights, and rate setting and financial oversight.
- Clearly define oversight responsibilities and communication lines among all state Medicaid staff, other state agency staff, contractors, and consultants.

### **Establish Clear Goals and Secure Input and Agreement from Stakeholders**

Experienced program managers stress the need to establish clear and measurable system and population-specific goals in the early stage of program planning. As discussed in the preceding section, program goals may relate to access, quality, costs, and LTSS system balancing. Stakeholder input should guide program goals. Veteran program managers stress the importance of getting buy-in from policymakers and stakeholders, including representatives of provider organizations, such as nursing homes and HCBS providers, MCOs, and consumer groups. This means involving them early and often and taking their advice seriously. One state official said that meaningful stakeholder involvement is what “makes for a great product....” Another said that getting provider and consumer input in the beginning is “how you discern where you are going to see push-back.”

### Clearly Communicate Expectations to Potential MCOs and Contract with Qualified Plans

It is particularly important to communicate with prospective MCOs about program goals. MCOs should understand what the state expects of them, and how the goals will be reflected in selection criteria. While formal and informal communication between the state and MCOs is essential at all stages of the process, it may be most critical during program planning and initial implementation. “Bring your health plans to the table; they should be your partners. The more they [health plans] understand the expectations on the front end, the easier the implementation will be. Design programs to solve the problems they are articulating,” advised a senior program manager.

Veteran program managers generally felt that establishing preferences for MCOs with previous experience serving older adults and people with disabilities was very useful but not essential (see figure 7). Selecting experienced plans can serve as an “insurance policy” in the managed care oversight process, since such plans are more likely to understand the needs of the population, either from managing LTSS in other states’ programs (for national plans) or from delivering LTSS within the state (for local plans). In addition, established MCOs are more likely to be financially sound. All of these factors can reduce the amount of time and resources needed to monitor plan performance later on. Contracting with experienced plans also may be preferable if the program start-up timetable is short or policymakers have set ambitious short-range enrollment or cost-savings goals. Experts agreed that plans that lacked experience can “buy missing expertise” by bringing in consultants or contracting with experienced providers, though plans may take longer to reach the expected level of performance.<sup>53</sup>

States beginning new programs or contracting with plans that are less experienced providing LTSS should expect to spend a great deal of time communicating with MCOs. One state reported that during the first several months after program start-up, it was

**Figure 7**  
**RFP/Contract Requirements and their Importance to New MLTSS Program Start-up**

<b>Critical</b>	Care coordination or care management components, and access-related standards including number and types of providers, rights of beneficiaries to continue care from current providers under some conditions, physical accessibility of services, and consumer-directed personal assistance options
<b>Critical</b>	Content and schedule of data files and reports that MCOs should submit to the state to enable it to monitor compliance with contract terms and requirements
<b>Critical</b>	Capitated rates that are appropriately risk adjusted for the enrolled population
<b>Very useful</b>	Requiring MCOs to demonstrate previous experience and competence serving older adults and people with disabilities and coordinating and providing LTSS, on their own or through contracted providers
<b>Useful but can be deferred</b>	Offering financial incentives (e.g., bonuses, rate withholds) for meeting or exceeding performance standards related to access, quality, and other aspects of service delivery

communicating with MCOs “on the phone or onsite daily and sometimes multiple times a day.” As operations became routine, calls with MCO representatives became less frequent, decreasing to a few times a week, and eventually to monthly calls and onsite audits.

### **Build Essential Elements into the Procurement**

Experienced program managers believe that the design of RFPs and contract terms is critical to program success. They identified particular areas that are important to prescribe or explain in detail in RFPs and contract terms (see figure 7). As one Medicaid official said, it is critical to “know what you want and define it very carefully.” Most MCOs found it very helpful to fully understand what is expected of them before programs begin, so the RFPs and contract terms should spell out those expectations clearly. According to one program manager, “You’ve got to figure out contract requirements [so both the state and the plans know what will be monitored] before you roll out your programs. That doesn’t mean it’s a one-time thing and it’s done. You start with what you think is adequate information and then you may have to amend your contracts. We amend our contracts every six months.”

### **Conduct MCO Readiness Reviews<sup>54</sup>**

States that contract with new plans, particularly those lacking experience serving people who need LTSS, stressed the need for “additional hand-holding.” For example, when Tennessee decided to add LTSS to the benefits covered by current MCOs, which had no experience managing LTSS, Medicaid staff conducted a thorough readiness review to determine whether the MCOs were ready to initiate services. MCO managers had to demonstrate their capacity to produce required reports, show how members’ needs would be assessed, and prove their ability to track referrals, timeliness of new members’ services, and ongoing care. As one Medicaid official said, “before we are ready to launch we need to know that plan by plan, step by step, member by member” everything is ready to go. States that are experienced with MLTSS, such as New York, also conduct onsite MCO reviews for new contractors.

### **Engage Qualified Staff and Contractors: Know Who Is Responsible for What**

Having the right staff involved in designing the MLTSS program, managing the procurement process, and setting up systems to monitor contract compliance is critical at all stages of the program, but especially at rollout. Veteran program managers stress the importance of engaging knowledgeable, skilled, and experienced people to be responsible for overall program management and for each major oversight function. The qualifications, or core competencies, for each of these roles were discussed in the section Organizational Models, Partners, and Key Inputs. If the Medicaid agency does not have staff with these competencies, it needs to (1) build it by retraining employees or hiring new staff, (2) borrow it from other state agencies, or (3) buy it from consultants and contractors.

For MLTSS programs, veteran program managers stressed the importance of having staff with experience and knowledge of LTSS delivery, HCBS quality, and care

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<sup>54</sup> A future AARP Public Policy Institute report will describe MCO readiness reviews in more detail.

coordination or care management specific to older adults and people with disabilities. Many veterans found that getting individuals with MCO experience can be advantageous. States also need staff to monitor MCOs' financial health and review the adequacy of rates and risk adjustment.

One program official said the state found it useful to “build on existing functions and expertise [within the state Medicaid agency and across state government].” But because building expertise can take time, using “an incremental approach [to staffing by building] on the infrastructure you already have” is recommended. And it is helpful to build on existing components of state government that have the capacity to perform MLTSS contracting and oversight functions. One official warned that going “from a purely FFS system to a managed care system that covers medical care, mental health and long-term care, is probably too much to do all at once.”

Clear lines of responsibility and communication are critical. All staff involved in MLTSS program management and contract oversight need to clearly understand their own roles and responsibilities, and those of all other team members. This level of understanding requires clarifying how information will flow between organizational units and vendors. Restructuring is often needed to align staff and responsibilities effectively. As one program manager said, “My program looks completely different [than it did under FFS]. We have new units, we got rid of old units, and we folded some units together.” While some reorganization may occur before program launch, restructuring may continue as programs mature. Almost all veterans reported that organizational structure evolved over time.

### **Establish Systems to Obtain Member Feedback**

Consumer advisory groups are often established to provide input and recommendations on program design. Veteran program managers say they also play a critical role in identifying problems in program rollouts and contact monitoring, so states planning new programs should regularly convene meetings of these groups. In addition, states need multiple mechanisms to obtain consumer feedback, such as surveys and hotlines. As one program manager said, “People want to be engaged and heard. [Consumer advisory boards] are an important component, but they aren't enough.”

New MLTSS programs also need to provide clear and detailed information on grievance and appeals processes. Usually, members must first contact the MCO if they believe they have been denied access to covered benefits, a choice of providers, or other guaranteed rights. States should have a system to monitor MCO grievance and appeals systems and to provide a fair hearing by an administrative law judge. To complement these avenues, many state programs set up a telephone hotline to receive complaints and questions. One program manager said, “It is critically important that you have a way to get information from members and providers about problems and issues; maybe it's a hotline or something else.” Whether a hotline is staffed by state personnel or by contractors, it is important to know which types of problems should be referred back to the plan for resolution before the state takes action. A program veteran warned, “It's difficult when state staff have to take calls [that should have gone to] MCOs; this can tie up [state staff] quite a bit and distract them from their other oversight and monitoring activities.”

### **Establish Robust IT Systems**

States need to have IT systems in place before program launch. States may need to develop entirely new IT systems to operate managed care programs, and MLTSS programs require specialized programs that can track changes in members' level of care and key care coordination processes. Effective contract monitoring depends on IT systems that track whether MCOs submit all required reports on time and that can aggregate encounter data to monitor beneficiary service use, cost patterns, quality measures, and other performance indicators. Provider payment capacity and the ability to determine program eligibility are critical components of MCO IT systems that must be operational when plans begin enrolling beneficiaries. While other systems capacities should be in place at the start of the program, veteran program managers say that analytic capacity can be built over time. IT systems are also essential building blocks for program evaluation. As one program manager said, it is important to “plan [program] evaluations before you start so you can collect the right data from the beginning, including encounter data.”

### **Develop and Tailor a Quality Assurance Plan**

Last but not least, program managers stress the importance of developing a detailed quality assurance strategy and a corresponding oversight system before new MLTSS programs begin. Federal rules require state Medicaid agencies to develop a quality assurance strategy for all types of MCOs.<sup>55</sup> But states with an existing quality strategy for MCOs covering acute and primary care need to completely rethink how they will monitor the quality of LTSS in a managed care delivery system, keeping in mind that consumer choice and quality of life are critical components of LTSS quality. A well-designed quality strategy will inform the state of the type of data that MCOs should report, the performance measures to which they will be held, and if necessary, the corrective actions and sanctions that apply for noncompliance. As programs mature, the quality assurance strategy and monitoring systems can shift the focus toward identifying priorities for MCO performance improvement projects. As one program manager said, “The first six months is about [ensuring a smooth] transition” from FFS delivery to managed care, so performance improvement projects can wait until later.

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<sup>55</sup> 42 CFR 438.202(a).

## CONCLUSION: ROOM FOR ALL STATES TO BUILD CAPACITY

This report has identified a range of capacities that are needed to monitor MLTSS plan performance. While the eight states examined in this study have learned from their experience and built strong oversight capacities over time, the emergence of promising practices in some states suggests room to improve. States planning new MLTSS programs face an even bigger challenge in trying to develop oversight capacity at a time when most Medicaid agencies are likely facing face shortages in staff and funding. **State and local governments employed almost 250,000 fewer people in 2010 compared to 2009, the first time in nearly 20 years that total state and local government employment decreased and another 250,000 state and local workers lost their jobs in 2011.**<sup>56</sup> State Medicaid agency staff resources may be further strained by many pressing demands, especially the need to prepare for expanded Medicaid coverage under federal health care reform. Local governments are also downsizing, which may further strain oversight capacity where local government agencies play important roles in eligibility determination, beneficiary counseling, and monitoring plan compliance with member assessment, care planning, and care coordination requirements.

At the same time, many partners stand ready to help states overcome these challenges and build oversight capacity. CMS has funded new technical assistance centers for states, some of which also receive support from private foundations. Partners in the private sector include EQROs, consumer advocacy groups, benefit counseling organizations, and national and local MCOs that have gained valuable experience operating MLTSS programs for older adults and people with disabilities. Perhaps the most important resources are other state Medicaid agency staff who can provide detailed descriptions of specific oversight activities. As one state Medicaid director said, “We spent a lot of time learning from what other states did [before starting our program],” time he considered worthwhile. By taking advantage of these resources and partnerships, state Medicaid agencies can build strong capacity to plan, monitor, and evaluate MCO performance and progress toward fulfilling the promise of MLTSS programs to improve care for older adults and people with disabilities.

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<sup>56</sup> U.S. Census Bureau, Annual Survey of Public Employment and Payroll Summary Report: 2010, January 2012) <http://www2.census.gov/govs/apes/g10aspep.pdf> and here’s a brief summary: <http://www.census.gov/newsroom/releases/archives/governments/cb11-146.html> ([http://money.cnn.com/2012/01/06/news/economy/state\\_local\\_jobs/index.htm](http://money.cnn.com/2012/01/06/news/economy/state_local_jobs/index.htm))



**APPENDIX A. DISCUSSION GUIDE**

**A. Organizational Structure of Medicaid Oversight of Managed Care Covering LTSS**

First, we’d like to understand how your state organizes the roles and responsibilities of managed care contract oversight for plans that provide LTSS to older adults and people with disabilities. This includes two types of plans: (1) those that cover LTSS only, and (2) those that cover LTSS as well as acute and primary care for the same beneficiaries, whether in the same or different contracts.

1. Can you briefly describe the organizational structure for oversight of these types of managed care programs? In other words, how is responsibility for the functions and activities involved in contract oversight divided within the Medicaid agency, across state agencies, local governments, and external contracted vendors and consultants? In other words, who does what?
2. Which entities do what within the state with respect to the following (“who does what”):
  - a. Provider network adequacy, especially home and community-based LTSS
  - b. Access and quality assurance
  - c. Beneficiary education and rights
  - d. Performance improvement and contract enforcement
  - e. Stakeholder/consumer engagement
  - f. Rate setting and financial oversight

Managed Care Oversight Function	Medicaid Agency Staff	Other State Agency Staff	Local Government Agencies	Private Vendors*	Others/ Consultants
1. Provider network adequacy					
2. Access and quality assurance					
3. Beneficiary education and rights					
4. Performance improvement and contract enforcement					
5. Stakeholder and consumer input <sup>1</sup>					
6. Rate setting and financial oversight					
7. Other core capacities not covered above					

\* If contracted vendors are involved, describe their roles/services and number of vendors.

3. What features of your state's current organizational structure do you find help or hinder effective contract oversight of these types of managed care programs?
  - a. What helps/makes the current structure work well?
  - b. What hinders/makes the current structure challenging?
  - c. *(For states that have managed care programs covering LTSS only and those that cover LTSS and acute/primary care):* Does the effectiveness of the state Medicaid oversight structure differ for plans covering LTSS only, compared to oversight of plans that include LTSS as well as acute and primary care? If so, how does it differ and why?

## B. State Medicaid Agency Staffing

Next, we'd like to ask about the number of state Medicaid agency staff, and those in other state agencies such as Departments of Aging, Disability, or Insurance, who work on program management (which includes program planning and policy, RFP development and negotiation, evaluation) and contract oversight of managed care plans that cover LTSS for older adults and people with disabilities.

We understand if you cannot provide precise numbers because some of the staff work on other managed care programs, or administer LTSS programs not provided through managed care plans. If you don't know the exact number of full-time employees (FTEs), we would like to get an approximate or general idea of the numbers of staff involved in program management and oversight.

1. About how many state Medicaid staff are involved in program management and contract oversight for these types of managed care plans?
  - Do any of the state Medicaid agency staff work solely on program management or contract oversight for these plans? If so, how many and what are their roles or functions?
  - Are different staff responsible for overseeing LTSS than those overseeing acute and primary care for older adults and people with disabilities?
2. About how many staff from other state agencies (aging, disabilities, insurance, health, other) are involved in program management and contract oversight of these types of plans?
  - Do any those staff work *solely* on Medicaid program management or contract oversight for these plans? If so, how many and what are their roles or functions?
  - Why did the state Medicaid agency involve staff from these other departments in program management or oversight? For example, did they have expertise in LTSS or management of chronic disease for older adults and people with disabilities that staff in the Medicaid agency did not have?
  - Are staff in other state agencies involved in all phases of program planning and oversight? In other words, were they only involved in the development of the RFP and in reviewing proposals from plans that bid for contracts? Or, do staff from these other agencies *continue* to have ongoing roles in program operations, oversight and management after the contract(s) were signed?

3. Have there been notable increases or decreases in the number of state Medicaid staff and those in other state agencies involved in program management and contract oversight of these types of managed care plans over the period in which your state has had such contracts?
  - What was the approximate change (increase or decrease) in the number of staff?
  - Why did the number of staff change? For example, did state budget cuts require staff layoffs or a freeze on new hires?
  - Has the change in number of staff improved or hindered the state's ability to effectively oversee plan performance?
4. Were there other reasons for change in number of staff? For example:
  - Increase/decrease in number of plans/contracts (approx. how many contract managers per plan or contract?)
  - Increase/decrease in the number of beneficiaries enrolled in such plans/contracts (approx. ratio of contract managers to beneficiaries?)
  - Staff needs changed due to use of IT/other technology to perform certain functions (which functions?)
  - Delegated responsibilities from state to *local agencies* for certain functions (which functions?)
  - Staff needs changed after state contracted with external vendors/consultants for certain functions (which functions [e.g., EQRO] became responsible for quality monitoring/improvement?)
  - Experience or efficiencies gained over time that reduced staffing needs (what made it more efficient and were efficiencies sustained?)
  - Greater complexity/needs of older adults and people with disabilities enrolled in these types of plans over time changed staffing needs (how?)
5. Based on your experience, do staff involved in program management and oversight of these types of plans need different qualifications than staff involved in oversight of managed care covering acute and primary care for adults and children? If so, what specialized experience, knowledge, education, training or skills do they need?

### **C. State Approach to Managed Care Oversight Roles and Functions**

Next, we'd like to understand in more detail *how* your state Medicaid agency and its partners (other state agencies, local government entities, contractors and consultants) carry out functions involved in oversight of managed care contracts and performance of plans providing LTSS, including those that also cover acute and primary care to the same set of older adults and people with disabilities. We'll go through five oversight functions commonly performed by most states.

### Provider Network Adequacy

1. What data or information does the state (or its contractors) collect to monitor the adequacy of plans' provider networks for delivering LTSS? For example:
  - Specific types of LTSS providers and services (home health agencies, nursing homes, personal assistance services, adult day health programs, adult foster homes, etc.)?
  - Geographic distribution/access (e.g., travel time)?
  - Providers' licensing/other qualifications or competencies?
  - Providers' ability to accommodate the needs of people with disabilities (e.g., physical, and language and communication access)?
  - Rely on accreditation agencies to certify network adequacy?
2. *(For states that have managed care programs covering LTSS, in addition to acute/primary care):* What data or information does the state (or its contractors) collect to monitor the adequacy of plans' provider networks for delivering acute and primary care?
3. Does the state (or its contractors) do anything to help MCO plans fill gaps in provider networks of LTSS? For example, by helping home care agencies, area agencies on aging or centers for independent living qualify as Medicaid providers?
4. Does the state require managed care plans providing LTSS to contract or cooperate with certain types of agencies that provide HCBS, or that specialize in care for older adults and people with disabilities? For example, does the state require plans to contract with area agencies on aging, centers for independent living, or community health centers?
5. If yes, why did the state establish this requirement? For example, to assure access to traditional providers of HCBS, or to culturally competent care?

### Access and Quality Assurance and Improvement

1. What data or information does the state (or its contractors) collect (and how often) to monitor plan performance in assuring access to and quality of LTSS for beneficiaries?  
For example:
  - Encounter data on services/claims?
  - Quality of care measures (process and outcome measures)?
  - Waiting times to get appointments or to start ongoing services?
  - Consumer experience and satisfaction surveys?
  - Reasons for calls and wait times for hotline?
  - Care processes important to older adults and people with disabilities, such as transitions from hospitals or nursing facilities to home and adequacy of case management
  - Referrals to LTSS that are not covered by plan (e.g., caregiver respite or support groups)?

2. How does the state (or its contractors) analyze the data and information to determine whether plans are complying with contractual requirements and meeting performance standards for access and quality of LTSS? For example:
  - Encounter data used to calculate performance measures and compare plan performance to external benchmarks?
  - By the Medicaid agency or by an external contractor (e.g., EQRO)?
  - Which measures and benchmarks are used (e.g., hospital or nursing home readmission rates, comparison to surveys of FFS beneficiaries in waivers)?
3. Does the state (or its contractors) identify systematic quality and access problems in the delivery of services, by plan or across all plans? For example, do you have an “early warning system,” or do you keep track of hotline calls by plan and by type of problem?
4. Does the state (or its contractors) prepare regular reports on managed care plan performance? If so, are they publicly available on the state Medicaid agency’s website?
5. Does the state (or its contractors) do anything else to improve access to or quality of care used by older adults and people with disabilities enrolled in managed care plans?

**Beneficiary Education and Rights**

1. Does the state do anything different regarding the education and information provided to beneficiaries about managed care plans (e.g., plan options, enrollment and disenrollment procedures and rights, benefits covered) than it does for beneficiaries enrolling in other types of managed care plans? If yes, please describe.
2. How does the state provide education and information to beneficiaries and family members? For example, what types of organizations are involved in providing it?
3. Does the state (or its contractors) review the plans’ beneficiary education materials?
  - If so, how often?
  - Does the state need to approve the materials before the plans can use them?
4. Does the state (or its contractors) review MCO plan materials for beneficiaries to determine if they are culturally and linguistically appropriate and accessible to the target population, or that translation services are available for non-English speakers?
5. Does the state have restrictions on plans’ direct marketing to consumers? If so, how are they enforced?
6. Is the process for investigating beneficiary complaints in managed care plans covering LTSS for older adults and people with disabilities different from that used to investigate complaints in other types of managed care plans? If yes, how is it different?
7. Does the state (or its contractors) regularly analyze data on enrollee complaints, grievances, and appeals of claims or service denials in managed care programs, and is

this done differently for beneficiaries in managed care plans for older adults and people with disabilities than younger adults and children enrolled in managed care plans?

8. Does the state have an internal ombudsman program devoted specifically to older adults and people with disabilities who are enrolled in managed care plans? If so, please describe what they do.

#### **Performance Improvement and Contract Enforcement**

1. Does the state have policies or incentives designed to improve performance by managed care plans that cover LTSS for older adults and people with disabilities? For example, does the state offer bonuses or rewards for plans that exceed certain performance indicators?
  - If yes, what are the indicators and thresholds used to award such bonuses?
  - Has the state awarded bonuses? If so, what level of effort is required to determine if plans qualify for bonuses? Does it involve high, moderate, or low time and resources?
2. Does the state adjust performance requirements in RFPs or contracts with plans to reflect changing expectations regarding quality of care outcomes, such as readmission rates, nursing home admission rates, care transitions, or consumer satisfaction? If so, can you provide an example?
3. What remedies does the state (or its contractors) use to address problems in meeting contract requirements or minimum standards for the delivery of LTSS? For example:
  - Meet with MCO(s) to discuss problems and solutions
  - Hold training sessions for MCO staff
  - Require MCOs to establish correction plans
  - Levy penalties or withhold bonuses
    - If yes, what type of penalties (fines, freezes on new enrollment, or other)?
    - How many times in total (all plans) were penalties or fines levied?
  - Contract termination for certain violations or repeated failure to correct problems
    - If yes, have any contracts ever been terminated?
    - How many times in total (all plans) and what was the nature of the violations?

#### **Stakeholder/Consumer Involvement and Feedback**

1. What kinds of things does the state do to involve and get feedback from stakeholders, such as consumer organizations, provider organizations, policymakers or others? For example:
  - Advisory Groups (the Medicaid Advisory Committee or one specific to the managed care program for older adults and people with disabilities)



- Public forums (online discussions, webinars, meetings)
  - Focus groups
  - Other, describe:
2. Do you find these mechanisms to be effective? Why or why not?
  3. Can you cite examples in which stakeholder involvement or consumer feedback resulted in a change in state managed care policy or contract terms related to contracts for older adults and people with disabilities?
  4. Does your state require consumer representation or participation in managed care organization governance (boards of directors) or advisory groups?
  5. Can you cite examples in which managed care plans have used consumer input and feedback effectively to improve their services?

**D. Overall Assessment**

1. What accomplishments of your state’s oversight system for managed care plans covering LTSS for older adults and people with disabilities are you most proud of?
2. Are there any oversight functions you would try to strengthen if you had more resources? For example, if you had two more FTEs for your Medicaid managed care program for older adults and people with disabilities, what tasks or responsibilities would you assign to them?
3. Based on your experience, what advice would you give to other states just starting managed care programs covering LTSS, or planning to add LTSS to managed care contracts that cover acute and primary care for older adults and people with disabilities? How should they organize and staff an effective contract oversight system?

**APPENDIX B. MLTSS PROGRAM OR PLAN PERFORMANCE MEASURES**

State	Measure Category					
	Health Care Use, Access, and Quality		Long-Term Services and Supports		Consumer Satisfaction or Experience of Care	
	Type	Latest public report	Type	Latest public report	Type	Latest public report
<b>Arizona</b>	<ul style="list-style-type: none"> <li>HEDIS-like indicators</li> </ul>	<i>EQRO Annual Report</i> , August 2011 (Oct. 2009–Sept. 2010 period): <a href="http://www.azahcccs.gov/reporting/reports/EQR.aspx">http://www.azahcccs.gov/reporting/reports/EQR.aspx</a>	<ul style="list-style-type: none"> <li>Initiation of HCBS care within 30 days</li> <li>HCBS vs. nursing facility mix percentages</li> </ul>	<i>EQRO Annual Report</i> , August 2011	<ul style="list-style-type: none"> <li>Member satisfaction (facilities, staff and caregivers, personal doctors and nurse practitioners, case managers, transportation program contractors)</li> </ul>	<i>Member Satisfaction Survey</i> , 2008: <a href="http://www.azahcccs.gov/shared/Downloads/surveys/ALTCS_Satisfaction_Survey_2008-FullReport.pdf">http://www.azahcccs.gov/shared/Downloads/surveys/ALTCS_Satisfaction_Survey_2008-FullReport.pdf</a>
<b>Massachusetts</b>	<ul style="list-style-type: none"> <li>HEDIS and HEDIS-SNP indicators</li> </ul>	Can be ordered through NCQA’s Quality Compass.	N/A	N/A	<ul style="list-style-type: none"> <li>Annual Consumer Satisfaction Survey</li> </ul>	N/A

State	Measure Category					
	Health Care Use, Access, and Quality		Long-Term Services and Supports		Consumer Satisfaction or Experience of Care	
	Type	Latest public report	Type	Latest public report	Type	Latest public report
<b>Minnesota</b>	<ul style="list-style-type: none"> <li>▪ HEDIS indicators</li> <li>▪ ACSC rates by plan</li> </ul>	<p><i>HEDIS Report, 2011</i> (separate report for each plan, with data for MSHO and MSC+ members shown separately)  <a href="http://www.health.state.mn.us/divs/hpsc/mcs/hedishome.htm">http://www.health.state.mn.us/divs/hpsc/mcs/hedishome.htm</a></p> <p><i>2009 Ambulatory Care Sensitive Condition (ACSC) Performance Measures Report, December 2010</i>  <a href="http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&amp;RevisionSelectionMethod=LatestReleased&amp;Rendition=Primary&amp;allowInterrupt=1&amp;noSaveAs=1&amp;dDocName=dhs16_160129">http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&amp;RevisionSelectionMethod=LatestReleased&amp;Rendition=Primary&amp;allowInterrupt=1&amp;noSaveAs=1&amp;dDocName=dhs16_160129</a></p>	<ul style="list-style-type: none"> <li>▪ CAHPS plus supplemental questions on health status changes and activity limits</li> </ul>	<p><i>HEDIS Report, 2011 and 2009 Ambulatory Care Sensitive Condition Performance Measure Report, December 2010</i></p>	<ul style="list-style-type: none"> <li>▪ CAHPS plus supplemental questions on satisfaction with care coordination</li> <li>▪ Voluntary changes in MCO (2008, first survey of MSHO members)</li> </ul>	<p><i>2010 Managed Care Public Programs: Consumer Satisfaction Survey Results, July 2010:</i>  <a href="https://edocs.dhs.state.mn.us/lfserver/public/DHS-5541B-ENG">https://edocs.dhs.state.mn.us/lfserver/public/DHS-5541B-ENG</a></p> <p><i>2009 Medical Assistance, MinnesotaCare and Minnesota Senior Health Options: Voluntary Changes in MCO Enrollment Report, April 2010</i>  <a href="https://edocs.dhs.state.mn.us/lfserver/public/DHS-5875A-ENG">https://edocs.dhs.state.mn.us/lfserver/public/DHS-5875A-ENG</a></p>

State	Measure Category					
	Health Care Use, Access, and Quality		Long-Term Services and Supports		Consumer Satisfaction or Experience of Care	
	Type	Latest public report	Type	Latest public report	Type	Latest public report
<b>New Mexico</b>	<p>“HEDIS-like” indicators:</p> <ul style="list-style-type: none"> <li>▪ Emergency room (ER) visits for preventable conditions</li> <li>▪ Hospitalizations for chronic conditions</li> <li>▪ Hospital readmissions within 30 days</li> <li>▪ Comprehensive diabetes care</li> <li>▪ Immunization for flu and pneumonia</li> </ul>	<p>EQRO, <i>CoLTS Performance Measurement Program and Performance Improvement Projects Audit</i>, 2011:  <a href="http://www.hsd.state.nm.us/mad/EqroReports.html">http://www.hsd.state.nm.us/mad/EqroReports.html</a></p>	<ul style="list-style-type: none"> <li>▪ Nursing home admissions and readmissions within 30 days</li> <li>▪ Home safety evaluations, percentage requiring follow up</li> <li>▪ Risk for falls assessed annually</li> <li>▪ Transition from nursing facility to community maintained in the community for six months</li> </ul>	<p>EQRO, <i>CoLTS Performance Measurement Program and Performance Improvement Projects Audit</i>, September 2011:  <a href="http://www.hsd.state.nm.us/mad/EqroReports.html">http://www.hsd.state.nm.us/mad/EqroReports.html</a></p>	<ul style="list-style-type: none"> <li>▪ CAHPS (access to care, timeliness of care)</li> </ul>	<p>EQRO, <i>Independent Assessment of New Mexico’s Medicaid Managed Care Program — CoLTSs</i>, June 2011:  <a href="http://www.hsd.state.nm.us/mad/pdf_files/salud/Independent%20Assessment%20CoLTS%20%2062411.pdf">http://www.hsd.state.nm.us/mad/pdf_files/salud/Independent%20Assessment%20CoLTS%20%2062411.pdf</a></p>
<b>New York</b>	<ul style="list-style-type: none"> <li>▪ “HEDIS-like” indicators (called QARR measures)</li> </ul>	<p><i>eQARR 2011 - An Online Report on Managed Care Plans Performance in New York State</i>:  <a href="http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2011/">http://www.health.ny.gov/health_care/managed_care/reports/eqarr/2011/</a></p>	<ul style="list-style-type: none"> <li>▪ Medicaid Redesign Team recommended LTSS quality metrics in 2011</li> </ul>	<p>Not applicable until 2012 or later</p>	<ul style="list-style-type: none"> <li>▪ Member satisfaction</li> </ul>	<p><i>Managed Long Term Care Plan Member Satisfaction Survey Report</i>,  <a href="http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_plan_member_satisfaction_survey.pdf">http://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_plan_member_satisfaction_survey.pdf</a></p>

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	Type	Latest public report	Type	Latest public report	Type	Latest public report
<b>Tennessee</b>	<ul style="list-style-type: none"> <li>HEDIS indicators</li> </ul>	<p><i>2011 HEDIS/CAHPS Report:</i>  <a href="http://www.tn.gov/tenncare/forms/hedis11.pdf">http://www.tn.gov/tenncare/forms/hedis11.pdf</a></p>	<ul style="list-style-type: none"> <li>1915(c) waiver sub-assurances, e.g., HCBS members with: level of care determination; signed form confirming choice offered; care plans reviewed/updated; critical incidents</li> </ul>	<p><i>TennCare Quality Assessment and Performance Improvement Strategy, 2011:</i>  <a href="http://www.tn.gov/tenncare/forms/qualitystrategy2011.pdf">http://www.tn.gov/tenncare/forms/qualitystrategy2011.pdf</a></p> <p>Strategy report lists measures collected. Unknown whether measures are also reported publically.</p>	<ul style="list-style-type: none"> <li>CAHPS surveys</li> </ul>	<p><i>2011 HEDIS/CAHPS Report</i></p>
<b>Texas</b>	<ul style="list-style-type: none"> <li>HEDIS indicators</li> <li>AHRQ Prevention Quality Indicators: percentage of hospital admissions, and ER visits for ACSCs</li> </ul>	<p>EQRO, Star+Plus 2008 Annual Quality of Care Report (approved 2/2010). Not found on website.</p>	<ul style="list-style-type: none"> <li>Nursing facility admission rates</li> <li>1915(c) waiver sub-assurances, (e.g., level of care determination, care plan development and maintenance, health and safety)</li> </ul>	<p><i>Performance Indicator Dashboard for Quality Measures</i> not applicable until 2012:  <a href="http://www.hhsc.state.tx.us/medicaid/umcm/Chp10/10_1_7.pdf">http://www.hhsc.state.tx.us/medicaid/umcm/Chp10/10_1_7.pdf</a></p> <p>Currently in the process of selecting small set of LTSS quality measures; EQRO asked to help in defining the measures.</p>	<ul style="list-style-type: none"> <li>CAHPS enrollee survey by EQRO</li> </ul>	<p><i>Texas Star+Plus Enrollee Survey Report, FY 2009, June 2009 (approved October 2009):</i>  <a href="http://www.hhsc.state.tx.us/reports/2010/Enrollee_Report_FY09.pdf">http://www.hhsc.state.tx.us/reports/2010/Enrollee_Report_FY09.pdf</a></p>

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<b>Wisconsin</b>	<p>“HEDIS-like” indicators:</p> <ul style="list-style-type: none"> <li>▪ Immunization rates</li> <li>▪ Diabetes under control;</li> <li>▪ Avoidable ER visits, and</li> <li>▪ Hospitalizations</li> </ul>	<p><i>Annual EQRO Report, July 1, 2009– June 30, 2010:</i>  <a href="http://www.dhs.wisconsin.gov/lcared/StateFedReqs/EQRO.htm">http://www.dhs.wisconsin.gov/lcared/StateFedReqs/EQRO.htm</a></p> <p><i>Wisconsin Long Term Care in Motion: 2009 Annual Report:</i>  <a href="http://www.dhs.wisconsin.gov/LTCare/Reports/DF/2009annualreport.pdf">http://www.dhs.wisconsin.gov/LTCare/Reports/DF/2009annualreport.pdf</a></p>	<ul style="list-style-type: none"> <li>▪ Percentage of members with change in ADL/IADLs</li> <li>▪ Case manager turnover rates by plan</li> <li>▪ Percentage in preferred living situation</li> <li>▪ Employment status</li> </ul>	<p><i>Wisconsin Long Term Care in Motion, 2009 Annual Report</i>  <a href="http://www.dhs.wisconsin.gov/LTCare/Reports/DF/2009annualreport.pdf">http://www.dhs.wisconsin.gov/LTCare/Reports/DF/2009annualreport.pdf</a></p>	<ul style="list-style-type: none"> <li>▪ Consumer satisfaction (participation in decision-making; communication; accessibility; comfort)</li> <li>▪ Voluntary disenrollment rates</li> <li>▪ “PEONIES” tool used to measure personal care outcome measures related to choice, personal experience, and health and safety.</li> </ul>	<p><i>Member Satisfaction Survey, 2010:</i>  <a href="http://www.dhs.wisconsin.gov/lcared/Reports/Index.htm">http://www.dhs.wisconsin.gov/lcared/Reports/Index.htm</a></p> <p>PEONIES survey introduced in 2010; results not yet reported by EQRO.</p>

ACSC = ambulatory care sensitive condition; ADLs = activities of daily living; AHRQ = Agency for Healthcare Research and Quality; CAHPS = Consumer Assessment of Health Providers and Services; EQRO = External Quality Review Organization; ER = emergency room; HEDIS = Healthcare Effectiveness Data Indicator Set; HCBS = home and community-based services; IADLs = instrumental activities of daily living.