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Chapter I

Purpose, background, and organization

A. Purpose of the toolkit and chapter overview

This toolkit provides guidance and examples of how states can monitor access to long-term services and supports (LTSS) provided through Medicaid and the Children’s Health Insurance Program (CHIP) managed care plans, as required by federal regulations at 42 C.F.R. §§ 438.66, 438.68, 438.206, and 438.207, 457.1218, and 457.1230.¹ Chapter I describes the history and growth of Managed Long Term Services and Supports (MLTSS) programs and recent federal requirements concerning state responsibilities for monitoring access to services covered by MLTSS programs. It then describes the sources and methods used to develop the toolkit. The last section of Chapter I describes the content and organization of the toolkit.

B. Background and context for the toolkit

Growth of MLTSS and access concerns

Long-term services and supports (LTSS) cover a wide range of medical and nonmedical services and supports for people with physical, cognitive, and mental health conditions as well as other disabilities or conditions. These can include institutional care provided in nursing facilities, intermediate care facilities for individuals with developmental disabilities, and mental health facilities, and home and community-based services (HCBS). HCBS include services and supports, such as (but not limited to) case management; homemaker, home health aide, personal care, adult day health, and habilitation (both day and residential) services; and respite care.



Chapter I at a glance

- This toolkit is intended as a resource for state Medicaid and CHIP agency staff who are developing or implementing monitoring practices to oversee access in Managed Long Term Services and Supports (MLTSS) programs. It highlights effective or promising practices currently used in states as examples.
- The toolkit was developed in response to the growth in MLTSS programs in recent years and concerns raised by federal oversight agencies about access to services and quality of care for individuals enrolled in MLTSS programs.
- Chapter I describes federal regulations issued from 2016 and 2020 and previous guidance from 2013 that establish access monitoring requirements for states operating MLTSS programs.
- Chapter I also highlights the importance of care quality, in particular the health and welfare of MLTSS enrollees. However, methods to assure quality of care broadly are outside the scope of this toolkit.
- The toolkit includes two additional Chapters: Chapter II describes key data sources and strategies for monitoring MLTSS access, and Chapter III provides examples of how to apply these strategies to monitor access to MLTSS.

¹ Unless stated otherwise, all references to Medicaid also apply to Medicaid-expansion CHIPs (MCHIP).

HCBS programs serve a variety of targeted population groups— such as older adults and people with intellectual or developmental disabilities, physical disabilities, or mental health and substance use disorders (MH/SUDs)— and provide opportunities for Medicaid and CHIP beneficiaries to receive services in their own homes and communities rather than in institutions. These Medicaid and CHIP benefits help enrollees manage their basic needs and live independently in the community.²

For more than a decade, many state Medicaid and CHIP agencies have shifted the delivery of LTSS from fee-for-service (FFS) systems, which pay providers for each service delivered, to managed care delivery models, which contract with managed care plans to arrange and pay for LTSS-covered benefits. In this document, managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PHIPs) as defined at 42 C.F.R. §438.2 that cover LTSS are referred to as “MLTSS plans.” As of July 2020, 24 states served a combined 1.7 million Medicaid beneficiaries through MLTSS programs, up from 8 states serving just over 100,000 beneficiaries in MLTSS programs in 2004 (CMS 2021; Saucier et al. 2012). The amount spent on MLTSS programs has grown accordingly, increasing more than threefold in the past 10 years, from \$6.7 billion in FY 2008 to \$30.1 billion in FY 2018 (Murray et al. 2021).

One reason that states turn to MLTSS is that it allows states to hold managed care plans accountable for LTSS access and quality (Libersky et al. 2018). For example, states can leverage MLTSS to improve access to HCBS by creating financial incentives for plans to shift the balance of LTSS from institutional care towards the HCBS that enrollees prefer. Holding a single managed care plan responsible for an enrollee’s medical and LTSS needs may also improve care coordination and whole person care. However, some of the operational processes that MLTSS plans use, such as selective contracting and utilization review, can unintentionally pose threats to access.³ Additionally, across all delivery systems, high staff turnover and shortages among the HCBS workforce and lack of affordable, accessible housing also create barriers to LTSS access.

Identifying and addressing threats to enrollees’ access to all covered services is a shared goal and takes the combined efforts of CMS, states, and managed care plans. This toolkit highlights proven and promising practices to help states and plans reach that goal.

² These activities are defined in terms of activities of daily living (which include eating, bathing or showering, dressing, getting in and out of bed or a chair, walking, and using the toilet) and instrumental activities of daily living (which include managing communication with others, transportation and shopping, house cleaning and home maintenance, managing finances, shopping and meal preparation, and managing medications (U.S. GAO 2020).

³ Recent investigations by the U.S. Government Accountability Office (GAO) and the Office of Inspector General (OIG) have confirmed performance problems among some MLTSS plans that may pose a risk to access (U.S. GAO 2017, 2020; OIG 2020).

Federal requirements for monitoring access in MLTSS

Federal regulations included in the 2016 and 2020 Medicaid and CHIP Managed Care final rules⁴ established several new requirements for network adequacy and access in managed care programs, including requirements for states to establish quantitative network adequacy standards for certain provider types and new requirements for monitoring and reporting on access. These requirements apply to managed care programs that include coverage for LTSS. Table 1 highlights federal regulatory requirements related to access in managed care programs, including MLTSS programs.

Table I.1. Federal requirements related to Medicaid and CHIP access

Sections of 42 C.F.R.	Topic
§ 438.4(b)(3)	Actuarially sound rates that are adequate for managed care plans to meet availability and capacity requirements
§ 438.10(g)-(h), § 457.1207 ⁵	Enrollee handbooks and provider directories
§ 438.14(b), § 457.1209	Requirements for Indians & Indian Health Care Providers
§ 438.66	State monitoring requirements
§ 438.68, § 457.1218	Network adequacy standards
§ 438.70	Stakeholder engagement
§ 438.110	Long-term services and supports (LTSS) member advisory committee
§ 438.206, § 457.1230(a)	Availability and timeliness of services
§ 438.207, § 457.1230(b) ¹ § 438.208(c), § 457.1230(c)	Assurances of adequate capacity and services, and identification, assessment, and treatment and service plans for enrollees with special health care needs or who need LTSS
§ 438.330(b)(3), § 457.1240(b)	Mechanisms to detect both underutilization and overutilization of services
§ 438.340(b)(1), § 457.1240(e)	Network adequacy and availability of services standards in the Managed Care state Quality Strategy
§ 438.358(b)(ii), § 457.1250(a)	External quality review (EQR)-related activities—mandatory validation of network adequacy
§ 438.364, § 457.1250(a)	EQR results—findings on the quality, timeliness and access to care in annual technical report
§ 438.416, § 457.1260	Plan records of grievances and appeals related to access
§ 438.602(g), § 457.1285	Transparency—posting contracts and data on service availability and accessibility on state websites

Note: All sections refer to 42 C.F.R. § 438, available at <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:40.1.1.8>, or 42 C.F.R. § 457, available at <http://www.ecfr.gov/cgi-bin/text-idx?SID=ca3cb9a31f8bd52c18f20b970f3c718d&mc=true&node=pt42.4.457&rgn=div5>.

¹CHIP regulation 457.1230 exempts CHIP managed care plans from the requirement to “Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.”

⁴ 2016 final rule available at <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered>, and 2020 final rule available at <https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicare-and-childrens-health-insurance-program-chip-managed-care>.

⁵ CHIP managed care requirements at 42 CFR § 457.1207 cross reference § 438.10, but the requirements at §§ 438.10(g)(2)(xi)(E) and 438.10(g)(2)(xii) do not apply to CHIP.

Prior to the release of the 2016 regulations, CMS also provided guidance on establishing and implementing MLTSS programs in its 2013 *Guidance to States using 1115 demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (CMS 2013). The guidance described ten essential elements that would increase the likelihood of a high quality MLTSS program; five of the essential elements relate to access, namely:

- Element #3 (Enhanced Provision of Home and Community Based Services), which requires MLTSS to be delivered in the most integrated manner and setting. Access to HCBS is a key component of achieving this goal.
- Element #6 (Person-Centered Processes), which requires MLTSS programs to use person-centered needs assessment, service planning, and service coordination policies and protocols. These steps provide critical gateways through which enrollees access services.
- Element #7 (Comprehensive, Integrated Service Package), which requires MLTSS plans to provide or arrange for all physical and behavioral health services and LTSS as specified through the person-centered assessment and service planning process.
- Element #8 (Qualified Providers), which requires states to ensure that MLTSS plans develop and maintain a network of qualified LTSS providers sufficient to provide adequate access to all services covered under the contract.
- Element #9 (Participant Protections), which requires states to establish safeguards that ensure health and welfare within the MLTSS program, including a critical incident management system and fair hearing protections that allow services to continue during an appeal.

Unique features of access in MLTSS

Several unique features of LTSS require that states monitor these services differently than medical services covered under managed care. First, the process of determining eligibility for LTSS and connecting enrollees with services includes many steps, including health and functional assessments, service planning, service authorization, and service coordination and monitoring (U.S. GAO 2020). States should monitor the successful completion of each step in the process to ensure that enrollees who need LTSS are connecting with service providers in a timely way. Second, LTSS includes institutional services where enrollees both live and receive services in a single location, as well as a wide range of HCBS in which some providers travel to an enrollee to deliver services. For these two service types, states should develop and monitor compliance with standards other than time and distance. For example, states could consider standards that measure the number of providers and staffing levels, through staff-to-member ratios or the percentage of time that a care manager spends on direct services (Lipson et al. 2017). LTSS also provide support to vulnerable populations, including older adults, people with intellectual or developmental disabilities, physical disabilities, or MH/SUDs, and children with complex medical needs. For these population groups, access that is difficult or inconsistent can lead to rapid declines in daily functioning and well-being. For this

reason, states should implement processes for monitoring access to LTSS that quickly identify, investigate, and resolve access barriers.

Relationship of access to quality of care, in support of health and welfare

Ensuring access to LTSS is only one component of supporting an enrollee's health and functional needs. For LTSS to have a meaningful impact on the enrollees who use them, these services and supports must also be high quality and guarantee personal health, welfare, and safety. For this reason, CMS requires states that operate MLTSS programs using 1915(c) waivers to assure health and welfare by designing and implementing systems that identify, address, and seek to prevent critical incidents (that is, instances of abuse, neglect, exploitation, and unexplained death) and use of restraints (CMS 2014).⁶ Critical incidents are events that bring harm, or create the potential for harm, to MLTSS enrollees and should be investigated.

CMS requires that states monitor the quality of LTSS provided through managed care as part of their state quality strategies, regular external quality reviews (EQR), and reporting of quality and performance measures. These activities are described in detail on Medicaid.gov⁷ so they will not be addressed in this toolkit. However, because many states have faced challenges in adequately identifying and investigating critical incidents, this toolkit discusses approaches to monitoring and overseeing critical incidents.

C. Sources and methods of toolkit development and selection of state strategies

This section describes the sources and methods used to develop the toolkit and the criteria for selecting examples of state access monitoring strategies for inclusion in the toolkit.

Sources and methods

The toolkit draws on information collected through publicly available documents and discussions with state Medicaid agency staff. Between May and August 2021, we reviewed managed care contracts, quality strategies, and EQR reports from states with MLTSS programs as well as publications and presentations from national organizations to identify contract language and state monitoring practices related to access. We then conducted semi-structured telephone interviews with five states to understand the practices in detail. We selected these states because their program documents suggested they had more robust monitoring strategies (for example, direct tests of access) or more detailed contract language and reporting requirements. Through these discussions, we learned about the state context in

⁶ State MLTSS programs that operate under other federal authorities, such as 1115 demonstration authorities, may be held to similar standards and assurances.

⁷ CMS describes its requirements related to quality of care at <https://www.medicaid.gov/medicaid/quality-of-care/index.html>.

which the strategies were developed, the factors that led to their successful implementation, and considerations for other states that may be interested in implementing similar strategies.

Throughout the toolkit, we use parenthetical citations to cite information drawn from reviews of state managed care contracts or other print sources. Reference lists for these sources are at the end of each section. Information on state practices presented without a parenthetical citation was drawn from interviews conducted in 2021.

Selection of state strategies

This toolkit includes strategies or practices that meet the following criteria: (1) one or more states described how the strategy was implemented and integrated into their monitoring practices, (2) the strategy has potential for adaptation or adoption by states with different infrastructure and resources, and (3) the strategy is consistent with the intent of the Medicaid and CHIP managed care network adequacy requirements. The toolkit is not intended to be an exhaustive list of strategies or options. State officials should consult with CMS to determine whether their proposed approaches—including strategies not described in the toolkit—comply with federal rules.

D. Organization of the toolkit

The remainder of this toolkit is organized into two sections: Section II describes key data sources and monitoring strategies. Section III discusses how to use these data and apply the strategies to monitor components of MLTSS program operations that enable and assure enrollee access to LTSS. These components include health and functional assessments and service planning, service authorization, provider network adequacy, timely access to covered benefits, critical incident monitoring, and cultural competency and physical accessibility of providers and services. Example states practices and related contract provisions to support state oversight are included throughout the toolkit.

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Chapter II

Overview of key data sources and strategies for ensuring and monitoring access to MLTSS

Federal regulations at 42 C.F.R. §§ 438.207(a) and 457.1230(b) require that states obtain documentation from MLTSS plans demonstrating that the plans have the capacity to serve all enrollees and comply with all state access standards. To ensure that states can obtain the documentation they need for effective oversight, state contracts with MLTSS plans should (1) clearly spell out network standards and access requirements and (2) specify the data that plans must submit to document compliance with these standards. States can also collect additional data to validate and supplement the data that MLTSS plans submit in these contractually required reports.

Table II.1 crosswalks the stages of MLTSS service provision to data sources that can be used to monitor access at each stage. It also identifies the toolkit chapters that describe how states can use each source. The remainder of this section provides definitions of each source.



Chapter II at a glance

Chapter II describes key data sources and strategies for monitoring access to MLTSS. These key data sources include:

- Lists or counts of in-network providers
- Secret shopper studies
- Critical incidents (also called serious or sentinel events)
- Appeals and grievances
- Electronic Visit Verification data
- Encounter data
- Enrollee surveys
- Plan documentation and in-person reviews

Chapter III provides examples of how states have or could use these data sources and strategies for access monitoring.

Table II.1. Data sources to monitor access at each stage of MLTSS service provision

Stages of MLTSS service provision	Where described in this toolkit	Data sources used to monitor access in MLTSS							
		Provider network lists and directories	Secret shopper studies	Critical incidents	Appeals and grievances	Electronic Visit Verification data	Encounter data	Enrollee surveys	Plan documentation and in-person reviews
Development of health and functional assessments	III.A				X			X	X
Service plan development	III.A				X	X		X	X
Service authorization	III.B				X	X		X	X
Network development: Number of contracted providers	III.C	X	X		X		X	X	X
Network development: Appropriateness of contracted providers	III.C	X	X		X			X	X
Service use and care coordination (to meet needs)	III.C				X	X	X	X	X
Timely access to covered benefits	III.D		X		X	X	X		X
Health and welfare	III.E			X	X			X	X
Cultural competency and physical accessibility	III.F	X	X	X	X			X	X

A. Provider network lists and provider directories

Although states screen and enroll all managed care network providers and can access each plan's provider directory on a plan's website, states may find receiving network data in a different format very useful. States can require that plans submit regular, up-to-date data files monthly, quarterly, annually, or with another frequency, and can specify formats, data fields, and file submission standards. States may also require that plans identify providers no longer participating in the network in a different format or on a different schedule than the directory updates required at 42 C.F.R. §§ 438.10(h)(3) and 457.1207. This information can be used to analyze provider network capacity and to verify the accuracy of the information provided to MLTSS enrollees in the provider directories required by 42 C.F.R. §§ 438.10(h) and 457.1207.

B. Secret shopper studies

Secret shoppers attempt to make appointments with providers in a plan's network, posing as enrollees. This strategy can help states assess whether providers are accepting new Medicaid or CHIP enrollees seeking MLTSS and complying with appointment wait times. States can use secret shopper studies to identify gaps in access for certain types of providers, to verify the accuracy of the information in provider directories, and to understand how quickly an enrollee with an immediate need can get an appointment. To conduct these studies, State

Medicaid and CHIP agencies can use existing staff, External Quality Review Organizations (EQROs), or other vendors. When EQROs conduct secret shopper surveys as part of the annual external quality review required by 42 C.F.R. §§ 438.350 and 457.1250 for managed care organizations defined at 42 C.F.R. § 438.2, states are eligible for an increased federal Medicaid matching rate for this activity. (See Chapter III Section C, Box III.C.3 for a detailed discussion of considerations for designing effective secret shopper studies in LTSS.)

C. Critical incidents⁸

CMS describes critical incidents as events that “adversely impact enrollee health and welfare and the achievement of quality outcomes identified in the person-centered plan” (CMS n.d.). Such events, which states may also call serious or sentinel events, typically include instances of abuse, neglect, exploitation, and unexplained death. States have flexibility to define critical incidents, and, depending on the state, critical incidents may also include unexpected hospitalizations, injuries requiring medical treatment, use of restraints or seclusion (authorized or unauthorized), instances in which beneficiaries do not receive all needed services, allegations of theft of a beneficiary’s money or belongings, medication errors, reports of missing persons, death, and attempted suicide (Libersky et al. 2019; Rivard et al. 2013).

CMS expects states to have systems in place to identify, report, and investigate critical incidents, but many states that operate MLTSS programs delegate much of the responsibility regarding critical incidents to MLTSS plans (Libersky et al. 2019; CMS 2013; Rivard et al. 2013). For example, some states may require MLTSS plans to receive critical incident reports from providers and investigate or review reports to protect members’ health and welfare (Libersky et al. 2019; Rivard et al. 2013).

Although CMS expects states to use information on critical incidents to improve the delivery of MLTSS, states determine how often and in what format MLTSS plans must report critical incidents, and these requirements are usually contained in the plan’s contract or other policy and procedural documents. Requirements usually include (1) types of incidents that the MLTSS plan or provider must report; (2) entity or entities with whom the plan or provider must file reports (for example, protective services, licensing body, and law enforcement); (3) timelines for reporting; (4) whether the plan, provider, and/or state are responsible for conducting reviews/investigations; (5) processes and time frames for conducting reviews/investigations; (6) required actions pending a review or investigation; and (7) any monitoring processes required for the plan and/or conducted by the state to ensure that policies and procedures related to critical incidents are being followed (Libersky et al. 2019).

⁸ The description of critical incidents, appeals, and grievances and complaints is excerpted from Libersky et al. 2019.

D. Appeals and grievances

Appeals: Federal rules give all Medicaid and CHIP managed care enrollees the right to file an appeal in response to an “adverse benefit determination,” which includes actions like an MLTSS plan’s decision to reduce, terminate, or deny previously authorized services or to deny payment for a service (42 C.F.R. § 438.400(b), 42 CFR § 457.1260(b)(2)(i)). For example, an enrollee could appeal a plan’s decision to deny coverage for a specific type of MLTSS care, such as personal care services, or to reduce the number of personal care attendant hours an enrollee is authorized to receive (U.S. GAO 2017). Federal requirements at 42 C.F.R. §§ 438, Subpart F and 457.1260 specify the general process and timeline for appeals but leave some process details to the discretion of states.

Grievances: An enrollee can file a grievance with an MLTSS plan to express dissatisfaction with any matter that cannot be appealed (42 C.F.R. § 438.400(b), 42 CFR § 457.1260(b)(2)(i)). For example, grievances might relate to difficulties getting an appointment with an MLTSS provider, concerns about the quality of care, a provider not treating the enrollee respectfully, or a provider or plan not respecting an enrollee’s rights. Enrollees may also submit grievances directly to the state in a manner determined by the state, such as to the state Medicaid agency or state long-term care ombudsman. After receiving information about the enrollee’s grievance, the MLTSS plan or state conducts an independent review and determines what, if any, steps are needed to resolve the grievance (U.S. GAO 2017). As with appeals, federal requirements at 42 C.F.R. § 438 Subpart F outline the general process and timeline for grievances but leave some process details to the discretion of states and MLTSS plans.

Similar to critical incidents, federal regulations require MLTSS plans to keep records about grievances and appeals but allow states to determine the details. 42 C.F.R. §§ 438.416(b) and 457.1260(h) require MLTSS plans to collect and retain information on general descriptions of the reason for each grievance or appeal; the date received; the date of each review, including review meetings; the resolution at each level of appeal or grievance; the date of resolution at each level; and the name of the covered person for whom the appeal or grievance was filed. States may require MLTSS plans to report aggregate counts of grievances and appeals filed in the reporting period, or information on grievances and appeals reported in a prior period by resolution status. States vary in the detail they require plans to report. For example, **Rhode Island** requires a simple report of clinical and administrative denials and appeals; others, including **Kansas** and **Tennessee**, require a more detailed reporting of appeals, including data on the number received, the type and name of the involved provider, descriptions of issues, timeliness of resolution, and outcome.

E. Electronic Visit Verification data

Electronic Visit Verification (EVV) systems use telephone- and computer-based processes to electronically verify and document when services provided in a particular location began and ended. Section 12006 of the 21st Century Cures Act (P.L.114-255) requires that states

implement EVV for all Medicaid personal care services (PCS) by January 1, 2021, and home health care services that require an in-home visit by a provider by January 1, 2023. These EVV systems must electronically verify the type of service provided, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time a service begins and ends. States that do not comply are subject to incremental Federal Medical Assistance Percentage reductions up to 1 percent, unless a state encounters unavoidable delays despite good faith efforts to implement on time.

EVV systems can help safeguard enrollee health and welfare by establishing a record of personal care and/or home health care services received that can be used to monitor enrollee access to care, including if care is provided timely. If states have the systems to support these analyses, EVV can be used to alert case managers in real time about missed visits to facilitate the provision of back up care. If EVV systems are linked to electronic plans of care or to service authorization systems, they can be used to monitor whether services provided in the home are delivered according to the plan of care and/or to authorized services. EVV data can also be used to validate the accuracy of other data sources such as encounter data (see description of encounter data in Section F below) or missed visits reports by comparing the information in each data source. In addition, EVV systems can be used to alert the state when an individual who self-directs is not receiving services in the amount, duration, frequency, and scope necessary to meet that individual's needs (CMS 2018).

F. Encounter data

As defined in 42 C.F.R. § 438.2, enrollee encounter data means the information relating to the receipt of any item(s) or service(s) by an enrollee for benefits covered under a contract between a state and an MCO, Prepaid Inpatient Health Plan, or Prepaid Ambulatory Health Plan that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818. Plans are required to submit encounter data to the state that provide details about the services delivered in each visit, including information on each service rendered, including the type of service or procedure, duration, location, provider type, and amount paid by the plan to the provider.

Because MLTSS plans are required to submit encounter data on enrollees' individual service use and states are required to validate encounter data, states can use these data to regularly monitor access and network adequacy. For example, states can use encounter data to analyze timely completion of functional assessments and service plans by comparing the date of enrollment to the dates of service on the encounter data. States can also use these data to monitor trends in service use by type, location, provider, or plan to identify patterns (for example lower than expected utilization compared to historical trends) that indicate potential access issues. States can also compare encounter data to the services authorized and included in an individual's care plan to identify any gaps in services authorized relative to services received. Encounter data can also be used to compare the providers that are rendering services to a managed care plan's provider directory to identify if an inordinate

number of non-network providers are providing covered services. This type of analysis could identify network deficiencies and/or inaccuracies in directories.

G. Access and quality measures and LTSS experience of care surveys

There are few standardized measures of access and quality that are specific to LTSS. The Medicaid and CHIP Adult and Child Core Set measures include standardized measures of access and quality, some of which may be relevant to assessing access to care for MLTSS enrollees. However, with one exception, these measures relate to medical or behavioral health care and are not MLTSS-specific. (See additional information referenced in Box II.1.)

To capture access and quality for MLTSS enrollees, several states voluntarily conduct one or more of the experience-of-care surveys listed below for people who use LTSS (hyperlinks to these surveys are listed in the box below):

Box.II.1. Medicaid and CHIP Adult and Child Core Set measures

As required by Section 1139B of the Social Security Act, each year the Centers for Medicare & Medicaid Services publishes sets of core measures showing the quality of care and health outcomes for adults enrolled in Medicaid and children enrolled in Medicaid and CHIP. These measures are referred to as the [Adult and Child Core Sets](#). In addition to measures of quality and experience of care for medical and behavioral health services, the Adult Core Set currently includes one measure that indicates whether states participate in the National Core Indicators survey, which asks about experience of care and quality of life for people with developmental disabilities who use LTSS.

- CAHPS Home and Community-Based Services Survey (HCBS CAHPS®). The HCBS CAHPS survey is a cross-disability survey for adults receiving long-term services and supports from state Medicaid home and community-based services and supports (HCBS) programs. It is designed to facilitate comparisons across state Medicaid HCBS programs that target adults with disabilities, (for example, older adults, people with physical disabilities, people with intellectual or developmental disabilities, persons with acquired brain injury, and persons with mental health and substance use disorders). CMS is the survey's measure steward. The survey is available to states free of charge for voluntary use in HCBS programs as part of quality assurance and improvement activities and public reporting.
- National Core Indicators (NCI)® is a voluntary effort by public developmental disability agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. The survey is proprietary and available to states for a fee.
- National Core Indicators-Aging and Disability (NCI-AD)™ is a voluntary effort by state Medicaid, aging, and disability agencies to measure and track their own performance. The core indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including service planning, rights, community inclusion, choice, health and care

coordination, safety and relationships. Like NCI, the survey is proprietary and available to states for a fee.

- Personal Outcome Measures® (POM). The Council on Quality and Leadership (CQL) POM is a valid and reliable tool for person-centered discovery and organizational change. A Personal Outcome Measures® interview explores quality of life outcomes and captures information on choice, health, safety, social capital, relationships, rights, goals, dreams, and employment, among other topics. It also captures information on the supports in a person's life, to better understand the effect particular services are having on individual outcomes. The Personal Outcome Measures® is a trademarked and proprietary tool.



Additional information

More information on the measures described here is available online:

- [CAHPS Home and Community-Based Services Survey \(HCBS CAHPS®\)](#)
- [National Core Indicators \(NCI\)®](#)
- [National Core Indicators-Aging and Disability \(NCI-AD\)™](#)
- [Personal Outcome Measures® \(POM\)](#)
- [CMS Measures for MLTSS Plans](#)
- [HCBS Recommended Measure Set RFI](#)

Though these surveys differ in their target population and focus, each contains questions that can support assessments of access for people who use HCBS (Lipson 2019).

Outside of experience of care surveys, states may also monitor quality and access through use of quality measures to monitor MLTSS.

CMS Measures for MLTSS Plans. This set of assessment and service planning measures (MLTSS-1 through MLTSS-8) provide information about assessment and care planning processes among MLTSS plan members that can be used by states, managed care plans, and others for quality improvement purposes and to compare the performance of MLTSS plans and programs within and across states (see box below for additional information). These measures include:

- Five comprehensive assessment and care planning measures, which assess the content and timeliness of assessments and care plans, as well as assessment, screening, and plan of care to reduce the risk of falls; and
- Three rebalancing measures, which indicate access to and availability of HCBS. These measures include Admission to an Institution from the Community, Minimizing Institutional Length of Stay, and Successful Transition After Long-Term Institutional Stay.

CMS is also developing an HCBS Quality Measure Set, informed by feedback gained through a request for information (RFI) on a Draft HCBS Recommended Measure Set. The HCBS Quality Measure Set may include measures from the quality measures and experience of care surveys listed above.

H. Plan documentation and in-person reviews

States include a wide range of reporting requirements in their contracts to support ongoing monitoring, including several described above. States can include any type of reporting requirements they wish in their managed care plan contracts. In addition, states may include blanket statements in their contracts that require plans to submit all reports specified in the contract as well as any future reports required by the state.

When states identify issues based on plan reports or other monitoring data, they may conduct on-site audits/in-person reviews to investigate further. For example, if plan reports on grievances and appeals indicate issues with access to care, states can use an in-person review to examine enrollee case records to validate that service authorizations reflect the same service types, amount, duration and frequency as the plan of care. States should investigate to understand reasons for discrepancies identified. States could also review enrollee case records for evidence that the enrollee's plan of care was forwarded to their primary care provider within the required timeframe.

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Chapter III

Applying access monitoring strategies to key MLTSS program operations

This chapter provides examples of how states can use the strategies described in Chapter II to monitor access. The Chapter is organized into six sections that represent key aspects of MLTSS program operations, such as initial and ongoing health and functional assessment and service plan development. This chapter is organized into the following six sections:

- A.** Initial and ongoing health and functional assessment and service plan development
- B.** Timely and appropriate service authorization
- C.** Adequate provider networks
- D.** Timely access to covered benefits
- E.** Health and welfare
- F.** Cultural competence and physical accessibility

Each section includes the following sub-sections: (1) an overview of relevant state and federal requirements, (2) sample contract language to support federal and state requirements, and (3) examples of state monitoring strategies.

A. Initial and ongoing health and functional assessment and service plan development

Federal and state requirements

Federal regulations at 42 C.F.R. §§ 438.208(c) and 457.1230(c) require that states identify people who need LTSS and that contracted MLTSS plans comprehensively assess their needs and develop treatment or service plans that meet specified criteria. MLTSS plans must also authorize LTSS based on an enrollee's current needs identified in the functional assessment and consistent with their person-centered service plan (438.210(b)(2)). States conduct reassessments for level of care either annually or when an enrollee's functional or medical status changes in a way that may impact their eligibility for Medicaid and CHIP-covered LTSS.

Functional assessments and service plans are important gateways through which enrollees gain access to services and supports. Functional assessments determine and document enrollee needs, and resulting service plans specify the type, duration, and amount of services that should be provided, as well as enrollee preferences, thereby establishing a standard against which access can be measured. Reassessments of enrollees' health and function can help states determine the effectiveness of the service plans by providing an opportunity to compare the services and supports received by an enrollee to those specified in the enrollee's service plan. A November 2020 GAO study found that plans were not always compliant with requirements for functional assessment and service planning, including timely completion of functional assessments, regular service plan updates, or other aspects of person-centered care, such as offering informed choices to the individual regarding the services and supports they receive and from whom (U.S. GAO 2020). This finding emphasizes the need for states to monitor the functional assessment and service planning process.

Contract provisions to support state oversight

To ensure timely and complete functional assessments, reassessments, and service plan development and updates, contracts with MLTSS plans should specify expected timeframes



Chapter III, section A at a glance

Health and functional assessments and the service plans that are developed to meet each person's needs and preferences form the foundation for measuring MLTSS members' access. To ensure timely and comprehensive functional assessments and service plans, states can do the following:

- Analyze plan-reported, monthly care coordination and functional assessment reports
- Selectively conduct focused reviews, such as functional assessment and service plan audits
- Use quality measures or consumer experience of care measures to assess timeliness and comprehensiveness of functional assessments and service plans, and enrollee perspectives on whether service plans reflect their needs and preferences
- Analyze encounter data to examine timeliness of assessments and service plan development (for example, by comparing the date of the assessment or service plan development compared to the date of enrollment)
- Monitor grievances and appeals related to the functional assessment and service planning process

and processes for completion of these activities. Box III.A.1 below includes example contract requirements from **New Jersey** and **Tennessee**. **Virginia**'s contract also specifies that the time frame for completing functional assessments varies based on population, with a shorter time for the most vulnerable populations. In an interview, state staff shared that varying the time frame by population gives the plans the ability to manage their caseloads and ensure that the highest risk members are prioritized for health risk assessments first. (Commonwealth of Virginia, Department of Medical Assistance Services 2021).

Box III.A.1: Example Contract Language

Tennessee: "For ALL CHOICES and ECF CHOICES Members... the CONTRACTOR shall... conduct a level of care reassessment at least once every three hundred sixty-five (365) days and within five (5) business days of the CONTRACTOR becoming aware that the member's functional or medical status has changed in a way that may affect level of care eligibility."

"Within five (5) business days of completing a reassessment of a member's needs, the member's Care Coordinator or Support Coordinator, as applicable, shall update the member's plan of care or PCSP to accurately reflect any changes in the member's circumstances and any impact on the member's needs."

New Jersey: "Within five (5) business days of the effective date of a new Member's enrollment into the MLTSS program, the Contractor's assigned Care Manager, or designee, shall initiate contact with the Member to establish a time for completion of the face-to-face visit for the purposes of creating an individualized and comprehensive plan of care. In addition, if the Member resides in a community alternative residential setting or institutional setting, the Care Manager, or designee, shall also contact the facility to inform the facility of the Member's enrollment and visit date. Initial contact may be made via telephone. Confirmation of the scheduled interview shall occur prior to the meeting.

1. The Contractor is responsible for obtaining a copy of an existing assessment or conducting a NJ Choice assessment system, completing the initial face-to-face visit and completing the Plan of Care, including Member's signature, within forty-five (45) calendar days of enrollment notification.
2. If the Member requests a date that falls outside these parameters, it must be documented within the Member's electronic Care management record."

"The Contractor shall ensure that all annual redeterminations are conducted eleven (11) to thirteen (13) months from the last NJ Choice assessment authorized by OCCO. Annual assessment date refers to the OCCO authorization or approval date. The Contractor is responsible for tracking annual redetermination dates to ensure compliance. Compliance for redeterminations is defined as one hundred (100) percent."

Sources: State of Tennessee. "MCO Statewide Contract with Amendment 14." July 1, 2021. Available at <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>. Accessed August 19, 2021.

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State monitoring strategies

Reviewing plan-reported, monthly care coordination, and functional assessment reports

Among states examined for this toolkit, the most common approach to monitoring compliance with functional assessment and service planning requirements was reviewing monthly reports from managed care plans on completed functional assessments and service plans.

For example, **Texas** collects member-level data, such as the date the service plan was established, the date it was last updated, and the level of service coordination provided. (Texas's contract requires that MLTSS plans assess members with high levels of service coordination—that is, higher needs—in a fewer number of days.) **Iowa** tracks level of care expiration dates to monitor compliance with timely reassessment requirements (Iowa Department of Human Services 2021). In **Virginia**, staff receive care coordination and functional assessment reports monthly and review the findings on monthly calls with plans.

Conducting focused reviews or audits

States may also conduct annual audits or reviews of functional assessments and service plans by selecting a statistically valid random sample from each MLTSS plan to validate whether functional assessments and service plans are completed accurately and timely. For example, **Texas** Medicaid agency staff collaborate with Health and Human Services Commission's (HHSC's) data analytics staff to pull a random sample of enrollees for functional assessment and service planning reviews based on criteria such as Resource Utilization Group (RUG) categories. Different enrollees are pulled into the sample each year—for example, in state fiscal year (SFY) 2020, Texas pulled enrollees with the highest-level RUGs, and in SFY 2021, enrollees with RUGs related to decline in physical functioning. Texas also typically pulls an extra sample based on the most frequently occurring RUGs for referrals submitted to the HHS complaints team on behalf of the enrollee reviewed in the previous year. Once the sample's enrollee level information is identified, Texas Medicaid agency staff reach out to contracted managed care plans for enrollee case file information. Based on the data collection responses, state agency utilization review staff assesses whether plans are compliant with specific performance measures related to functional assessment and service planning. These performance measures include: (1) a measure related to completion of the correct functional assessment and service planning forms and required documentation of this activity, (2) a measure of whether documented needs were incorporated into the service plan, and (3) a measure of timeliness of functional assessments and reassessments.

Florida requires that MLTSS plans submit a Case Management File Audit Report quarterly, at a minimum, with a statistically significant sample LTSS enrollees (see Box III.A.3). The report provides the state with information on plan-compliance on various contractual elements (for example, that the plan of care reflects assessed needs). Florida Medicaid quality staff review the reports and relay any violations with contract requirements to Medicaid contract

managers so they can investigate discrepancies with contract requirements and issue fines as applicable (that is, liquidated damages). Fines are issued on public record, which can help to encourage compliance.

Florida conducts an annual desk review of a sample of the case files reviewed by the plans to validate the findings of the Case Management File Audit Reports. The Agency addresses any discrepancies directly with the plans. In addition, Florida conducts a quarterly case file review of a statistically significant sample size of enrollees in each plan, which evaluates compliance with many of the Plan of Care and Case Management requirements found in the Case Management File Audit Report. The results of this quarterly monitoring are shared with the plan and any non-compliance is addressed and remediated as required.

Box III.A.3: Florida's Case Management File Audit Report

Florida requires MLTSS plans to submit a Care Management File Audit report, which must address the following "Primary elements of the Plan of Care":

- Plan of care services are specific to assessed needs.
- The plan of care documents the service type, amount, duration, and frequency of services.
- Service authorizations are consistent with services documented on the enrollee's plan of care.
- A new plan of care was developed annually.
- The plan of care is reviewed and, if necessary, updated in a face-to-face visit with the enrollee or authorized representative every ninety (90) days.
- The plan of care is reviewed and updated in a face-to-face visit more frequently than once every ninety (90) days if the enrollee experiences a significant change.
- The case manager conducted a face-to-face visit within five (5) business days following an enrollee's change of placement type (e.g., HCBS [home and community-based services] to an institutional setting, own home to assisted living facility, or institutional setting to HCBS) or following a significant change in an enrollee's condition.
- The plan of care includes the enrollee's personal goals.
- The plan of care was forwarded within ten (10) business days of initial development or any subsequent updates to the enrollee's primary care provider.
- The plan of care was forwarded within ten (10) business days of initial development or any subsequent updates to the facility where the enrollee resides."

Source: Florida Statewide Medicaid Managed Care (SMMC)-LTC Program. "Case Management File Audit Report Pursuant to Attachment II, Exhibit II-B, Section IX." n.d. Available at https://ahca.myflorida.com/medicaid/statewide/mc/report_guides/cmfar.shtml. Accessed August 19, 2021.

Using enrollee surveys and other quality measures to monitor timely and complete functional assessments and service plans

Ensuring that the services and supports specified in enrollees' service plans reflect their needs and goals is a critical component of evaluating whether Medicaid and CHIP programs and MLTSS plans provide person-centered care. One approach for monitoring this is the use of enrollee surveys, which states, managed care plans, EQROs, or a contractor can conduct on a periodic basis. **Kansas** conducts periodic enrollee surveys and calculates the percent of

survey respondents who reported receiving all services as specified in their service plan; **New Jersey** also conducts these surveys and collects the percent of waiver individuals who have service plans that are adequate and appropriate to meet their needs and personal goals, as indicated in the functional assessment (HMA 2016). **Texas** nurse reviewers conduct member interviews with MCO Service Coordinators to gauge member experience with MLTSS and their participation in service planning processes.

Many states use the HCBS CAHPS and/or the NCI-AD surveys to measure enrollee experience of care, including access and quality. The HCBS CAHPS survey is a cross-disability survey that can be used to measure enrollee experience with home and community-based services. It includes 69 questions; the core questions include several topics that address access and quality of care, including getting needed services, reliability of HCBS staff, choice of services, medical transportation, and personal safety (CMS n.d.). The NCI-AD survey includes domains for access to community and access to needed equipment, as well as domains related to care coordination and safety (NCI-AD n.d.).

Outside of enrollee surveys, states can also calculate measures of timely and comprehensive functional assessments and service planning. Four of CMS's MLTSS performance and quality measures, which also have been added to the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS^{®9}) measure set, can be used for this purpose:

- Comprehensive Assessment and Update
- Comprehensive Care Plan and Update
- Shared Care Plan with Primary Care Practitioner
- Reassessment/Care Plan Update After Inpatient Discharge

Pennsylvania uses these four HEDIS[®] measures to monitor quality and access in its Community Health Choices (CHC) program. Specifically, the measures inform CHC program evaluation, quarterly quality reviews with CHC health plans, meetings between senior state and plan leadership, and in public meetings with stakeholders (Lipson et.al. 2020). The **Arizona** Health Care Cost Containment System carried out a performance improvement project in 2019 to measure the Arizona Long Term Care System's performance and improvement on three of the MLTSS measures: LTSS Comprehensive Assessment and Update, LTSS Comprehensive Care Plan and Update, and LTSS Shared Care Plan with Primary Care Practitioner (AHCCCS 2019).

States can also develop their own measures that assess similar content. In addition to requiring plans to report the four MLTSS assessment and service plan measures and other nationally standardized measures (such as HEDIS[®] measures), **Florida** requires MLTSS plans



Additional resources

For more information regarding the four quality measures for MLTSS, please refer to the [Measures for MLTSS Plans Technical Specifications and Resource Manual](#).

⁹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

to report on a state-developed measure: percentage of recipients' service plans reviewed on a face-to face basis at least every three months and updated as appropriate (State of Florida 2021).

Reviewing encounter data and grievances to determine timeliness of functional assessments and service plans

Although we did not find a state example in our document review or from interviews, encounter data could theoretically be used to monitor plan compliance with timely functional assessment and service planning requirements. For example, states can compare the date of service in encounter data for functional assessments or service plan development to the members' date of enrollment to evaluate the timeliness of functional assessments. Similarly, if grievances data collected by the state are sufficiently detailed, states could review it to identify potential issues with timely or appropriate functional assessment or service planning for enrollees, for example by analyzing grievances related to the timeliness of services.

B. Timely and appropriate service authorization

Federal and state requirements

As part of developing service plans, MLTSS plans review the total amount or cost of services and supports proposed to determine which services to authorize based on enrollees' level of need. Federal regulations at 42 C.F.R. § 438.210(b)(2)¹⁰ require that prior authorizations use consistent review criteria, consult with the requesting provider as appropriate, and authorize LTSS based on an enrollee's current needs identified in the functional assessment and consistent with the person-centered service plan. MLTSS plans must also authorize services according to standard and expedited timelines, and enrollees must receive timely notification of denials of service authorization requests or changes or reductions in previously authorized services (42 C.F.R. § 438.210(c)-(d)). Within these parameters, the service authorization process gives plans the ability to review and provide input on coverage of services typically before they are rendered; however, inappropriate delays in the process or denials of services can create barriers to access.



Chapter III, section B at a glance

- Timely and appropriate service authorization ensures that enrollees can access the services and supports specified in their service plans.
- Many states monitor timely and appropriate service authorization through review of grievances and appeals and desk reviews; however, some states described desk reviews as labor intensive.
- Electronic Visit Verification data can help states monitor service fulfillment standards.

¹⁰ CHIP regulation 457.1230 ([https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-L#p-457.1230\(d\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-D/part-457/subpart-L#p-457.1230(d))) exempts CHIP managed care plans from the requirement to "Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan."

Monitoring timely and appropriate service authorization is especially important in situations where changes, denials, or reductions in authorized services are more likely to occur—such as when enrollees are reassessed for services, or when they transition from FFS to managed care or from one MLTSS plan to another. Timely notification of these changes enables enrollees and care coordinators to plan ahead to prevent any resulting gaps in services and supports or to file an appeal in response to an adverse benefit determination.

Contract provisions to support state oversight

Strong contract standards related to service authorizations set clear expectations and enable states to monitor compliance. Section 2.9.7.2.5.13 of **Tennessee’s** managed care contract includes an example of strong service authorization requirements (see Box III.B.1 below) that specifies the required content of service authorizations, standards for timeliness and consistency with the service plan, and the use of EVV systems to support this monitoring.

Box III.B.1: TennCare II Managed Care Contract Language

“For purposes of CHOICES or ECF CHOICES HCBS, service authorizations shall include the amount, frequency, and duration of each service to be provided and, except for services provided through Consumer Direction, the schedule at which such care is typically needed or preferred, if applicable, and whether the member requests or agrees to accept flexibility in his/her typical schedule, as applicable and after the member has received education on options and advantages of flexible scheduling; the requested start date; and other relevant information as required by TENNCARE..”

“2.9.7.14.5.1 Authorizations as defined pursuant to Section A.2.9.7.2.5.13 are entered into the EVV system timely and accurately, including any changes in such authorizations based on changes in the member’s plan of care or PCSP.

2.9.7.14.5.2 Authorizations provided by the CONTRACTOR outside the EVV system are consistent with authorizations entered by the CONTRACTOR into the EVV system and with the member’s currently approved plan of care or PCSP.

224 2.9.7.14.5.3 Any actions required by the CONTRACTOR to resolve exceptions in the EVV system, e.g., a change in the service authorization, are completed within three (3) business days so that claims for services can be submitted for payment.

Source: State of Tennessee. “MCO Statewide Contract with Amendment 14.” July 1, 2021. Available at <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>. Accessed August 19, 2021.

State monitoring strategies

Reviewing grievances and appeals

Analyzing grievances and appeals is a common method used by states to monitor service authorizations or denials or changes to services. Some states such as **Kansas** (KanCare) categorize grievances and appeals by reasons for filing, which include “denial or reduction of services” and “service authorization” subcategories (Libersky et al. 2019). These data identifiers give them the ability to monitor patterns in these events and examine them by plan, population group, geographical region, and provider group. For example, if state data

finds that service use in a given program is down at the same time the number of appeals of adverse benefit determinations is up, this may suggest that an MLTSS plan's denial of payment or authorization for services is limiting access to services (Libersky et al. 2020).

Conducting desk reviews and audits

State may also conduct desk reviews of service authorizations, which should include detailed reviews of MLTSS plan records documenting service authorization changes or denials, processing time, and dates and methods of enrollee notifications about denials or changes. **Florida** selects a statistically valid random sample of enrollees every quarter and reviews case files to determine compliance with various contract requirements including whether authorizations were completed timely and addressed all assessed enrollee needs. If the state notices a sizable number of authorization-related complaints for a given plan in its complaint hub, the state adds five to ten enrollees to the plan's case file sample for closer review. Florida's case file reviews also look at whether MLTSS plans appropriately notified enrollees whose service requests were reduced or denied. **Virginia** also routinely conducts desk reviews of a random sample of authorization requests. In an interview with the state, Virginia noted that using desk reviews to monitor timely and appropriate service utilization is more labor-intensive than monitoring grievances and appeals or plan-submitted reports related to service authorization, but desk reviews are an important complement to these other methods, as they are the best way to assess if plans are completing authorizations timely and appropriately. Prior to reviewing a random sample of files as part of on-site reviews, **Idaho** also reviews and approves plans' policies and procedures for service authorizations (Idaho Department of Health and Welfare n.d).

C. Adequate provider networks

Federal and state requirements

42 C.F.R. §§ 438.68 and 457.1218 require that states develop quantitative network adequacy standards for eight provider types, including LTSS, that account for anticipated Medicaid enrollment, expected utilization of services, the ability of network providers to communicate with limited English proficient enrollees in their preferred language, and other factors. States must publish these standards on their public website (42 C.F.R. § 483.68(e), § 457.1218). In addition, 42 C.F.R. § 438.207 and § 457.1230(b) require that MLTSS plans provide assurances and supporting documentation that demonstrate they have the capacity to meet the state’s standards for access to care per 42 C.F.R. §§ 438.68 and 438.206.

Contract provisions to support state oversight

Most states establish time and distance standards for services in which the enrollee travels to the provider by specifying maximum mileage limits or time that enrollees must travel to receive certain types of LTSS that are not delivered in individuals’ homes. These standards typically vary for urban versus rural areas. Table III.C.1 below includes examples of such standards from MLTSS contracts.



Chapter III, section C at a glance

Federal regulations require that MLTSS plans have provider networks that are adequate to provide access to all services covered under the plan contract. States can monitor this requirement by:

- Reviewing provider directories and using secret shopper calls to validate directory information on network providers,
- Analyzing plan compliance with network adequacy standards using plan-submitted reports and geographic mapping software, and
- Tracking and trending grievances and appeals to assess plan compliance with provider choice and other standards and conducting focused audits or desk reviews.
- This section also includes a description of state strategies for monitoring access in rural and frontier areas (see Box III.C.5).

Table III.C.1. Example time and distance standards

State	Area	Provider type	Standard
Delaware	State-wide	Community-based residential alternative setting	1 within 30 miles of member’s residence
Virginia	Urban	Non-primary care services	75 percent of members must have access to non-primary care services within 30 miles of member’s residence or 45 minutes driving time
	Rural	Non-primary care services	75 percent of members must have access to non-primary care services within 60 miles of member’s residence or 75 minutes driving time
New Mexico	Rural	Assisted Living Facility; Personal Care Service Agency, Delegated; Personal Care Service Agency, Directed; and Nursing Facility	90 percent or more of managed care organization’s enrollees have access to 1 provider of each type within 60 miles

Sources: Delaware Health and Social Services. “Division of Medicaid and Medical Assistance 2020 Medicaid Managed Care Master Service Agreement.” May 31, 2020. Available at https://www.dhss.delaware.gov/dhss/dmma/files/mco_msa_2020.pdf.

Kimsey, K. “CCC Plus: Determining Network Adequacy.” Virginia Department of Medical Assistance Services presentation. August 29, 2017. Available at <http://www.advancingstates.org/sites/nasuad/files/Final%20HCBS%20Network%20Adequacy.pdf>.

State of New Mexico Human Services Department. "Centennial Care: 2018 Validation of Network Adequacy." June 30, 2020. Available at http://nmhsd-old.sks.com/uploads/FileLinks/8087bfcd31b14dfe8b92a6206b890b19/Net_Ad_18_Final_Leadership_Approved.pdf.

Because some LTSS do not require people to travel to a provider to receive services and supports, states also commonly develop standards other than time and distance. For facility-based providers or providers that travel to enrollees (for example, those that deliver services in the home), many states require plans to demonstrate that enrollees have a choice of at least two providers per HCBS provider type per geographic area (for example, county). **Virginia's** MLTSS contract requires that plans provide members with at least two providers for each of four LTSS provider types (see Box III.C.1). **New Jersey** requires that managed care plans have, at a minimum, two providers available to provide HCBS in each county; the provider does not need to be located in the county of the member's residence but must be willing and able to serve residents of that county (State of New Jersey, n.d.).

Box III.C.1: Virginia's provider network standards for providers that travel to the member

"The Contractor shall provide Members with at least two (2) providers for each type of service listed below in each CCC [Commonwealth Coordinated Care] Plus locality unless where an exception is granted by the Department:"

1. Home Health
2. LTSS [long-term services and supports] – Personal Care, Respite Care and Respite Care LPN [Licensed Practical Nurse]
3. LTSS – Skilled Nursing, Congregate Nursing, and Congregate Respite Nursing
4. LTSS – Service Facilitation
5. CMHRS [Community Mental Health Rehabilitation Services] – Crisis Stabilization, Crisis Intervention, Intensive In-Home, Mental Health Skill Building, Peer Recovery Support Services, Behavioral Therapy, Intensive Community Treatment

Source: Commonwealth of Virginia, Department of Medical Assistance Services. "Commonwealth Coordinated Care Plus MCO Contract for Managed Long Term Services and Supports." 2021. Available at <https://www.dmas.virginia.gov/media/3579/final-ccc-plus-contract-renewal-effective-july-1-2021.pdf>.

State monitoring strategies

Reviewing provider directories or data files to validate information on network providers

Reviewing provider directories against network requirements is one strategy for monitoring network adequacy. However, the accuracy of these directories must be validated periodically. In addition, many HCBS providers are independent providers of PCS and may not be included in directories that list provider agencies; therefore, states may need to supplement this method with other strategies for verifying provider network information. **Tennessee**, for example, contracts with its EQRO to conduct quarterly provider data validation surveys using statistically valid samples of providers in each plan. The state can issue fines (called liquidated damages) "if data for more than 10 percent of providers is incorrect for individual data

elements” (State of Tennessee 2021). **Florida** is developing programming to include assisted living facilities and nursing homes in its weekly validation of provider network files. To complete this validation, the state’s EQRO analyzes each plan’s contractually required weekly update to their online provider directories to evaluate compliance with provider to enrollee ratios and time and distance standards.

Using secret shopper calls to determine plan network adequacy and provider directory accuracy

Validating the accuracy of information in provider directories is necessary but insufficient for assessing the actual capacity of provider networks. Plans must also ensure provider willingness and capacity to accept Medicaid and CHIP enrollees and provide specific services.

To address this, states could require MLTSS plans to assure that all, or a specified percentage of network providers accept new Medicaid and CHIP enrollees and provide services included in the contract. States could also use Medicaid claims analyses to determine which providers are actively caring for enrollees. For example, **New Jersey** is developing a new reporting framework that will stratify MLTSS plan access metrics (for example, geo-access analyses, capacity limits, and/or provider-to-enrollee ratios) by actively participating providers (for example those with a certain number of Medicaid claims and claims totaling a specified dollar amount) and those who are not actively serving plan enrollees. Because some providers may be in a plan’s network but not accepting new Medicaid and CHIP patients or not seeing many patients, this stratification will help the state interpret network adequacy standards (e.g., time and distance standards and provider to enrollee ratios) results among a plan’s active network (i.e., the plan’s “effective network”).

Box.III.C.2. Concentration of Care Among Small Percentage of Physicians in Medicaid Managed Care Networks

A [recent study of Medicaid managed care networks](#) in four states found that care was highly concentrated among a small number of physicians (25 percent of primary care physicians provided 86 percent of the care and 25 percent of specialists provided 75 percent of the care), and more than a third of the physicians listed in these directories provide services to ten or fewer Medicaid beneficiaries in a year. The authors suggest states regularly evaluate Medicaid managed care networks using strategies such as secret shopper calls and analyses of Medicaid claims data to identify “ghost” and “peripheral” providers and focus audit efforts on these groups. In addition, the authors suggest penalties for plan non-compliance (Ludimorsky et. al., 2022).

As described in Chapter II, states can also use secret shopper studies to assess whether providers are accepting new clients and complying with appointment wait times. In these studies, data collectors attempt to make appointments as if they were enrollees. However, to make accurate conclusions about access, secret shopper studies need to carefully define the research questions they will answer (for example, is the provider directory up to date, does the provider accept new clients, and what is the wait time for an appointment). The survey must also be designed with an appropriate sample frame that specifies the plans, providers, regions to target, and number of calls needed.

In a previous toolkit on behavioral health provider network adequacy (Horner et al. 2020), CMS and the toolkit authors identified a number of questions to work through in designing a secret shopper study—chief among them is which providers to call. For example, for states interested in using secret shopper calls to assess long-term services and supports, home health or home care agencies may be an appropriate focus. Calls to these providers could aim to validate whether the providers are: (1) participating in the plan network, (2) accepting new clients, (3) employing staff with certain language or care-specific skills (for example, Spanish speaking staff, ability to bathe a client, or qualifications such as skilled registered nurse/ licensed practical nurse or various therapists), and (4) available to provide appointments soon. (Note that these example scenarios assume the person is already enrolled in the MLTSS plan and assessed as needing supports with activities of daily living in the home.)

To ensure that data are collected in a consistent way, secret shopper studies should develop scripts for callers to follow. The scripts could help callers pose as caregivers seeking help for a family member and reference the plan their family member is enrolled in as well as what they need help with (for example, getting out of bed, bathing, and dressing) and any other required characteristics. Scripts should also plan for how callers will respond to questions around level of support (for example, help needed four days a week with getting out of bed, dressing, bathing, and cooking) across the study. Finally, scripts could describe how callers might get around specific questions about IDs (for example, people who are pretending to be caregivers can say they don't know a member ID and are just calling to gather information on how to support their loved one). These survey design considerations are discussed in additional detail in Box III.C.3. below.

Box III.C.3. Considerations for designing a secret shopper survey

States or their contractors who are conducting secret shopper studies should carefully consider the following questions.

- **Which plans?** Although some state Medicaid agencies may be able to survey all managed care plans, those with many plans may need to select a subset. For example, states can consider targeting plans that represent the largest enrollment or the plans that have the greatest network adequacy concerns.
- **Which providers?** States interested in understanding availability among all MLTSS provider types should include a representative sample of each type of provider of interest, such as home care or home health agencies, adult day health centers, nursing facilities, or transportation providers. States with shortages of particular provider types may want to oversample providers with known shortages or those for whom Medicaid access may be limited. States could also use encounter data to identify in-network providers with no Medicaid encounters (that is, “ghost providers”) or lower-than-expected encounters (that is, “peripheral providers”), and then focus secret shopper calls on this subset of providers (Ludimorsky et. al., 2022).
- **Which regions?** States can aim for a representative sample statewide or focus on specific regions where access problems are more likely, such as rural areas or those with a high number of access related grievances or appeals.
- **How many calls were attempted and completed?** Consider the time available to complete the calls. If resources are constrained, focus on calling provider types of interest in areas with known shortages.

- **Is the provider directory up to date?** Many provider directories are out-of-date and include providers who no longer contract with the managed care plan. To gauge whether provider directories are up to date, the survey could assess whether the providers listed in plan directories have current, active contracts with the plans. Secret shoppers could ask providers, “Do you currently accept my insurance? I have [plan name].”
- **Does the provider accept new clients?** Even providers who have active contracts with managed care plans may not be accepting new clients. Some provider directories indicate whether providers are accepting new clients, but this information may not be updated regularly. In addition, a home care agency may be in network, but may not have specific provider types available to work with enrollees. To ascertain how many providers within the network accept new clients, secret shoppers can ask, “Are you accepting new clients that need personal care services?” or “do you have respite care providers available to work with new clients?” for example.
- **What is the wait time for an appointment?** Despite timely access to care requirements, managed care enrollees may experience long wait times to begin receiving MLTSS services or to receive the next appointment. For example, there may be a wait time for a functional assessment, or for a personal care aide to be identified and to start working with a plan member. To understand whether wait times adhere to a state’s timely access standards, secret shoppers can ask questions such as, “What is the soonest available date for a functional assessment for a new client?”
- **How can surveyors respond to questions in a consistent way?** To help survey staff sound like actual enrollees, prepare a script with instructions on what to do when the provider (1) asks the caller to leave a message, (2) refers the caller to a central number for multiple providers, (3) no longer works in the office or practice, (4) requires a referral, or (5) asks for detailed information the caller does not have such as a medications list or Medicare card number. Survey staff should record when these questions are asked and their responses, as the results may influence the secret shopper study findings.

Using geographic mapping reports and provider network files to monitor network adequacy

Many states rely on geo-mapping algorithms to compare driving time and distance to network adequacy standards and generate reports and maps as part of their oversight monitoring. Geo-mapping can be conducted by state staff or states can contract with a vendor to perform this work. Such information can help states quickly assess areas of low network adequacy where additional monitoring and oversight may be needed to ensure members can access services when they need them. For example, **Idaho** also uses geographic analyses to assess plan compliance with provider network standards (see Box III.C.4). **Texas** conducts regular “geo-mapping” analyses by county that plot each MLTSS plan’s network providers against its enrolled members to determine provider proximity to members and plan compliance with contract standards. MLTSS plans not in compliance with standards are subject to corrective action plans. Depending on the severity and frequency of the non-compliance the plan may be subject to liquidated damages (Texas Health and Human Services, 2021).

To assess compliance with the standard of two HCBS providers per provider type per county, **New Jersey** requires MLTSS plans to submit quarterly certified provider network files, which are analyzed by the Division of Medicaid Assistance and Health Services (DMAHS) to determine plan compliance. DMAHS discusses any concerning findings or trends during

individual performance meetings with plans. Failure to remedy or show sufficient progress addressing network deficiencies may result in formal Notices of Deficiency or Liquidated Damages as specified in the MTLSS contract.

Box III.C.4: Idaho's use of geographic mapping

"On an annual basis, the Health Plans produce a geographic analysis of their provider networks to determine the percentage of Enrollees in Idaho's urban counties that have access to a provider within thirty (30) miles of their residence and the percentage of those Enrollees residing in rural counties that have access to a provider within forty-five (45) miles of their residence. The report distinguishes home and community-based services from other types of services, such as primary care, emergency services, and behavioral health. The Health Plans also provide the results of their annual provider network survey, which is used to determine provider compliance with the required timelines for care and service delivery. The SOW [statement of work] requires that the Health Plans' provider networks be "appropriate to meet the needs of the diverse ... [enrollees] ... and must ensure the availability of services 24-hours a day when medically necessary."

Source: Idaho Department of Health and Welfare, Division of Medicaid. "Idaho Medicaid Managed Care Quality Strategy: Medicare Medicaid Coordinated Plan Idaho Medicaid Plus." n.d. Available at <https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=863&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1>.

Collecting and analyzing staffing and quality measures

States may require MLTSS plans to collect and submit various quality measures to monitor network adequacy. **Texas** developed new measures focused on access to community attendant services in response to direction from the state legislature. These measures include the number of community attendant service coordinators versus the number of open positions posted by MLTSS plans and quarterly turn-over rates for service coordinators, which indicate how many LTSS providers have left their position. These positions must be refilled, and changes in staff can disrupt continuity of care for plan members. The state will use these metrics to assess MLTSS plan progress toward building adequate LTSS provider networks.

Tennessee requires MTLSS plans to produce network development plans that include, at a minimum, a summary of the nursing facility network, by county, and a summary of HCBS provider networks, including community-based residential alternatives, by service and county (State of Tennessee 2021).

Tracking and trending grievances

States may also monitor the adequacy of provider networks by tracking and trending grievances. For example, states or plans can track trends on the number of grievances related to network providers not accepting new Medicaid clients. States can also analyze trends in these types of grievances by region, and they could follow up with focused reviews of provider networks in specific geographic areas or for LTSS services with higher numbers of grievances.

Monitoring strategies for rural and frontier areas

Box III.C.5 describes monitoring strategies used by states for rural and frontier areas.

Box III.C.5: Monitoring strategies for rural and frontier areas

Ensuring appropriate network adequacy in rural areas has been a long-standing challenge in many states due to low provider supply, especially for LTSS. Many states address provider network challenges in these areas by developing time and distance standards that differ between urban and rural or granting exceptions to existing standards consistent with 42 C.F.R. §§ 438.68(d) and 457.1218 and requiring plan network development activities. Below are three state approaches.

In some rural **Virginia** counties, there are no LTSS providers of various types, so the state issues exemptions for MLTSS plans operating in those areas. As part of the exemption process, the MLTSS plan must submit a detailed action plan for network improvement with actionable and measurable goals as well as milestones for reaching compliance. The state assists MLTSS plans that have been granted an exemption in developing their provider networks by sharing provider files and facilitating connections between LTSS providers and plans when possible.

Source: Commonwealth of Virginia, Department of Medical Assistance Services. "Commonwealth Coordinated Care Plus MCO Contract for Managed Long Term Services and Supports." 2021. Available at <https://www.dmas.virginia.gov/media/3579/final-ccc-plus-contract-renewal-effective-july-1-2021.pdf>.

In **Kansas**, MLTSS plans that cannot meet its network adequacy standards may request an exception to these requirements as well. The state considers these requests based on several factors:

- Utilization patterns in specific service areas
- The number of Medicaid providers in that provider type/specialty practicing in service area
- The history of member complaints regarding access
- Specific geographic considerations
- Level of care needed by members for that county
- The proposed long-term plan by the MLTSS plan to address the access to care gap in its network

Source: KanCare. "Geoaccess Reporting Requirements." Updated September 8, 2020. Available at <https://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/geo-access-standards.pdf?sfvrsn=6>. Accessed August 10, 2021.

On a quarterly basis **Florida** publishes on the state website a list of provider types by county for which there are fewer than two licensed providers in the area. Plans operating in these counties receive an automatic waiver of the two-provider-per-county network adequacy standards. However, they are required to utilize providers in surrounding counties to provide covered services, and to provide transportation for enrollees to these providers as needed. In addition, plans are required to continue to build their networks in rural areas, and to monitor FloridaHealthFinder.gov, the website where plans can locate licensed providers (including Adult Day Care Centers, Adult Family Care Homes, Assisted Living Facilities, Home Health Agencies, Hospice, 24/7 ER Services Facilities, Nursing Homes, and Substance Abuse Treatment Facilities), to identify if any new providers have become available that the plan might contract with. In addition, MLTSS contracts require that plans' annual network development plan includes a description of coordination with provider associations and other outside organizations.

Source: State of Florida, Agency for Healthcare Administration. "Missed Services Report Summary." n.d. Available at https://ahca.myflorida.com/medicaid/statewide_mc/report_guides/msr.shtml. Accessed August 22, 2021.

D. Timely access to covered benefits

Federal and state requirements

Federal regulations at 42 C.F.R. §§ 438.206 and 457.1230(a) require that states ensure services are available and accessible to people enrolled in Medicaid and CHIP managed care plans in a timely manner, including to those with limited English proficiency or physical or mental disabilities. It also requires that network providers offer hours of operation that are no less than what is offered to commercial enrollees or a comparable Medicaid FFS population (for example people who use FFS HCBS). 42 C.F.R. §§ 438.207 and 457.1230(b) require that managed care plans, including MLTSS plans, provide assurances and supporting documentation that demonstrate they have the capacity to meet the state's standards for access to care.

General approaches to monitoring timely access across all Medicaid and CHIP services include establishing and enforcing standards on hours of operation and appointment wait times. In the context of LTSS, measuring timely access also includes assessing whether MLTSS plan enrollees receive timely access to the services outlined in their service plan, which specifies the type, volume, and frequency of services they need. A 2018 Medicaid and CHIP Payment and Access Commission report found that tracking and reporting instances where a beneficiary was authorized to receive a service, but the service was not provided on time or at all, was a preferred standard for assessing access to HCBS among stakeholders interviewed (MACPAC 2018).

Accordingly, many states require MLTSS plans to meet standards for service fulfillment as part of timely access requirements. Service fulfillment standards measure the gap between services authorized and services received. States may evaluate this gap either in terms of the length of time between the initial service authorization and the delivery of the service, or the quantity of services authorized versus the quantity of services delivered (Ne'eman 2018). As of 2017, 31 percent of state MLTSS programs utilized service fulfillment standards (Lewis et al. 2018; Ne'eman 2018).

To monitor timely access requirements, states can specify a maximum wait time for services provided in an individual's home (for example, personal care and home modifications). In this case, the standard would measure the time between requesting or authorizing a service and receiving it, which might vary depending on whether the services are provided on a one-time



Chapter III, section D at a Glance

At the most basic level, access to care requires that MLTSS plans provide MLTSS according to an enrollee's plan of care in a timely manner. States can monitor this requirement by:

- Monitoring time to receive authorized services through plan-reports and Electronic Visit Verification analyses.
- Using encounter data and geographic mapping software to identify patterns in service use.
- Monitoring provider hours of operation and appointment wait times through secret shopper studies.
- Tracking and trending grievances and appeals related to lack of timely access to care and conducting focused audits or desk reviews.
- Using grievances and appeals to validate plan-submitted reports.

or ongoing basis (Lipson et al. 2017). (Additional examples for monitoring in-home provided services are described below.)

Contract provisions to support state oversight

State contracts commonly include requirements that services are delivered in the manner and frequency specified in the service plan. Some contracts include requirements that speak to timely service initiation. For example, **Texas's** STAR+PLUS contract requires that community-based attendant services are initiated within seven days after service authorization. And the state's STAR+PLUS managed care manual requires service coordinators to outreach to enrollees no later than a month after the service plan development date to ensure services are in place and if not, to help the enrollee arrange care and document the result (see Box III.D.1 for more details).

Box III.D.1: Texas Timely Access Contract Language

The STAR+PLUS contract requires that: "MCOs must ensure that a minimum of 90% of Members who are authorized to receive community attendant care services have timely access to such services. For purposes of this paragraph, timely access is within seven days from the authorization per STAR+PLUS Expansion Managed Care Contract."

Source: Texas Health and Human Services Commission. Attachment A – STAR+PLUS, Dallas and Tarrant Service Areas RFP, General Contract Terms & Conditions. Version 1.38. Available at: General Contract Terms & Conditions. <https://www.hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/starplus-expansion-contract.pdf>

The state's managed care manual requires that: "no later than four weeks after the [Individual Service Plan] ISP start date, the Service Coordinator or a member of the Service Coordination team must contact the Member to determine whether medically and functionally necessary services identified in the assessment process are in place and maintain documentation of the contact and result. At the time of that contact, if services that should be in place are not in place the Service Coordinator or a member of the Service Coordination team must help the Member arrange care and document the result."

Source: Texas Health and Human Services. "Texas Medicaid and CHIP Uniform Managed Care Manual. LTSS Quality Measures Technical Specifications." Chapter 10.1.12, Version 2.3. April 5, 2021. Available at <https://www.hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/texas-medicaid-chip-uniform-managed-care-manual>.

In addition, as described in Chapter II, states are required to implement EVV for all Medicaid personal care services by January 1, 2022, and home health care services that require an in-home visit by a provider by January 1, 2023. Accordingly, many state contracts with MLTSS plans specify requirements for MLTSS plans to use EVV systems, which enable plans and states to monitor members' timely access to care. For example, **Tennessee** requires its MLTSS plans to use an EVV system to track services delivered in the home, including personal care, attendant care, in-home respite, and home delivered meals. EVV systems track the services delivered relative to the plan of care. If a provider does not arrive at an enrollee's home within a specified period following the scheduled time, the system generates immediate alerts to the plan and provider organization (Lipson et. al., 2017).

State monitoring strategies

Using performance measures and plan-submitted reports

Many state practices examined for this toolkit quantify time to receive authorized LTSS through performance measures, which are reported by MLTSS plans to the state in contractually required reports. By quantifying these requirements, states can better track and identify systemic issues to pursue corrective actions. Example measures from three states are in Box III.D.2 below.

Box III.D.2: Performance measures to assess timely access to care in Texas, Minnesota, and New Jersey

- Texas** developed a comprehensive set of performance measures to assess the quality of home and community-based services (HCBS), including a measure called “Timeliness of initiation of community based attendant services after managed care organization authorization of services.” In this case, timeliness is defined as within 7 days. MLTSS plans are required to report this metric quarterly, and the measure is included in the state’s managed care quality dashboard. The state monitors MLTSS plans’ performance and imposes contractual remedies as determined appropriate. Texas is exploring use of Electronic Visit Verification data to determine the number of new community-based attendant service initiations in the reporting period.

Sources: Texas Health and Human Services. “Texas Medicaid and CHIP Uniform Managed Care Manual. LTSS Quality Measures Technical Specifications.” Chapter 10.1.12, Version 2.3. April 5, 2021. Available at <https://www.hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/texas-medicaid-chip-uniform-managed-care-manual>.

Texas Health and Human Services. “10.1.11. LTSS Quality Measures Template.” Available at <https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/10-1-11.xls>. Accessed August 2, 2021.

- As part of the state’s HCBS Access Project to assess, monitor, and evaluate access to HCBS, **Minnesota** developed a service performance and accountability measure called “Percent of ‘planned’ HCBS that were received,” defined as “the mean percentage of planned units of service (from the service plan) compared to billed units, adjusted for months alive and eligible.” Failure to receive “planned” HCBS may suggest there is insufficient system capacity to deliver needed services, and/or barriers to accessing these services in a timely way. The measure currently only applies to fee-for-service HCBS.

Source: Minnesota Department of Human Services. “Home and Community-Based Services (HCBS) Access Project Overview.” February 2019. Available at https://mn.gov/dhs/assets/HCBS-access-project-overview_tcm1053-373537.pdf.

- New Jersey** has developed several performance measures specific to its MLTSS program, including “MLTSS HCBS Services are delivered in accordance with the Plan of Care including the type, scope, amount, frequency, and duration.” To construct this measure, the External Quality Review Organization conducts record reviews of a sample of member plans of care and reports findings to the state annually as part of the care management audit process.

Source: State of New Jersey, Department of Human Services. “Contract Between State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services and ____ Contractor.” January 2021. Available at <https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>. Accessed on January 18, 2022.

New Jersey requires MLTSS plans to submit a Monthly Unstaffed Case Report, which captures information about enrollees who do not have their full personal care or private duty nursing hours filled. The report is intended to ensure that plans are effectively monitoring and remediating cases that are fully or partially unstaffed due to network adequacy, workforce challenges, or member-driven reasons. New Jersey cross references complaints and grievances against these reports to validate the plans' report completeness and accuracy. **Tennessee** requires MLTSS plans to submit several reports, surveys, and participate in audits to support the state's oversight of timely access. Box III.D.1 below lists these contractually required reports. Tennessee also requires plans to submit detailed reports on the timeliness of non-emergency medical transportation services, including the scheduled and actual pick-up time, actual departure time, and odometer reading at pick up and drop off, among others (State of Tennessee 2021).

Box III.D.1: Contractually required reports of timely access in Tennessee

Since 2010, Tennessee has measured the timely initiation and consistent provision of home and community-based services (HCBS) according to a member's plan of care, noting this assessment as a key aspect of the state's network adequacy requirements. The state's contracts require MLTSS plans to submit the following for one or both of its MLTSS programs:

- Service Initiation Report that "details services that have not been initiated and the reasons for the delays. Additionally, this report tracks services that are being received, timeliness of initiation, and services that have yet to be authorized. The MCOs [managed care organizations] participate in monthly calls with TennCare LTSS [long-term services and supports] to discuss the report data and identify opportunities for improvement."
- Late and Missed Visit Report that "tracks late and missed visits for personal care, attendant care, and home-delivered meals in CHOICES, and personal assistance and supportive home care in ECF CHOICES to determine when workers are not providing services pursuant to a member's PCSP [person-centered support plan]. TennCare uses these reports to identify and address potential network adequacy concerns, and to ensure that members are receiving services in accordance with the PCSP."
- Utilization Report that "tracks members who have been without long-term services for periods of longer than 30–59 days, 60–89 days, and more than 90 days. This report also details why a member has not received services and when services are expected to begin."

TennCare's contracts also specify that it audits new and existing member records in CHOICES and ECF CHOICES to address identification of services in the PCSP, MCO authorization of services, and timely initiation of services. In addition, these audits address the referral, intake and enrollment processes, MCO response time and documentation and for ECF CHOICES, and MCO performance related to completion of required processes to help members understand and explore individual integrated employment and self-employment options. The audits take a deep dive into a sample of PCSPs to determine whether MCOs are delivering all services in each individual's PCSP.

Source: State of Tennessee. "MCO Statewide Contract with Amendment 14." July 1, 2021. Available at <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>.

Using electronic visit verification data to assess timely access to services

An additional tool in monitoring different aspects of time to service initiation or delayed care can involve drawing on EVV data for personal care and home health services for in-home visits by a provider (Lynch 2019). As described in Chapter II, these EVV systems must be able to verify the following: (1) the type of service provided, (2) the individual receiving the service, (3) the date of service, (4) the location where the service was delivered, (5) the individual provider, and 6) the time the service began and ended (MACPAC 2019).

Since 2017, **Tennessee's** CHOICES contract has required its MLTSS plans to use EVV systems to track services, including personal care, attendant care, in-home respite, and home-delivered meals (State of Tennessee 2021). According to the state's MLTSS contract, the member's care coordination team will ensure that services are scheduled according to the member's service plan. For example, care coordinators are required to monitor EVV data in real time for enrollees transitioned from a nursing facility to a community-based setting to ensure services are provided according to the plan of care. EVV data are used to alert care coordinators to any missed visits so that immediate action can be taken to schedule back up care. Tennessee also requires MLTSS plans to submit EVV Monitoring Reports as part of its ongoing monitoring activities. (Information about contractually required EVV reports in Tennessee is in Box III.D.3 below.)

Box III.D.3: Contractually required EVV reports in Tennessee

"The CONTRACTOR shall provide an Electronic Visit Verification (EVV) Monitoring Report in a manner and frequency as specified by TENNCARE. The purpose of this Report shall be to facilitate TennCare oversight of the CONTRACTOR's ongoing monitoring of services logged through the EVV system, including but not limited to overlapping visits, as well as remediation to address findings and support system improvement, as required by Section A.2.9.7.14."

Source: State of Tennessee. "MCO Statewide Contract with Amendment 14." July 1, 2021. Available at <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>.

Virginia compares EVV data to waiver enrollment information to develop a list of waiver enrollees not using any services. If the state observes patterns of lower-than-expected utilization, the state will reach out to its colleagues who monitor the contracts with a particular plan to understand whether there are issues related to access in certain areas. Virginia is currently developing a system to electronically house service plans and defining standardized service plan elements that will be captured in these systems to facilitate electronic collection of these data, which could then be compared to EVV data to monitor whether services are being provided according to the plan of care.

One state interviewed for this toolkit noted that comparing EVV data to service plans can only identify gaps in care for enrollees who are authorized for a service. This state suggested that identifying cases in which enrollees had been assessed but had not yet received services was particularly important given the shortages in HCBS providers that many states face in the

wake of COVID-19. To address this challenge, states could require plans to report the amount of time between the completion of the assessment and the date on which services were authorized.

Using encounter data to identify patterns in service utilization

As noted in Chapter III., Section C, encounter data can also be used to monitor MLTSS plan enrollees' use of services and to identify potential access problems. For example, **Virginia** uses encounter data and data visualization software to look at utilization at the county level.

This enables the state to identify areas where there are fewer enrollees using PCS than the number of individuals authorized to receive it, for example. State staff can also map this information against where providers are located to identify geographic areas where providers are not being utilized by enrollees. Virginia creates reports for plans that show which of their providers are not providing services to enrollees and reviews these reports (among other findings) with plans on weekly and monthly calls. State staff explained that they work with their plans to ensure that the plans are providing services to enrollees where expected. As noted in Chapter II, Encounter data can also be used to compare the providers that are rendering services with those listed in the managed care plan's provider directory to identify whether an inordinate number of non-network providers are providing covered services. This type of analysis could identify network deficiencies and/or inaccuracies in directories.

Box III.D.4: Virginia: Medicaid Management Information System (MMIS) upgrades to facilitate improved access monitoring

Virginia is revamping their MMIS; one piece of this upgrade will include a care management module that will enable the state to receive daily feeds of service authorizations from the MLTSS plans. State staff explained that this will be key to evaluating access as it will enable them to compare services authorized to services received.

Assessing provider hours of operation and appointment wait times using secret shopper studies

To monitor standards on hours of operation and appointment wait times, states may conduct direct tests, such as secret shopper surveys, using either state Medicaid and CHIP agency staff, the state's external EQRO, or other vendors. Conducting these secret shopper studies with home health and home care agencies specifically can assist states in evaluating timely access to covered in-home services. These surveys most commonly include telephone calls to providers to assess compliance with state standards. States have great flexibility in designing these studies, including which provider types to sample, what questions to focus on, and what regions to survey (Lipson et al. 2017). See the previous section C, Box III.C.3 in this chapter for more on designing effective secret shopper studies in LTSS.

Analyzing grievances and appeals data, and conducting focused audits or desk reviews

Tracking trends in the volume of grievances and appeals related to access to LTSS is a crucial component of oversight activities. Typical monitoring practices involve reviewing overall trends in grievances and appeals, investigating delays in MLTSS plan processes, and

discussing patterns in access issues with MLTSS plan managers (Lipson et al. 2012). Grievances and appeals can also provide insight into timely access of LTSS, as long as states can clearly distinguish whether these adverse events are related to access.

In designing grievances and appeals systems, states should establish clear labels and stratifications for grievance and appeal types that allow for detailed analysis of issues. For example, as part of its accreditation process, **Tennessee** collects plan-level grievances data according to categories established by the National Committee for Quality Assurance, including “Quality of Care”, “Access”, “Attitude/Service”, “Billing/Financial”, and “Quality of Practitioner Office Site.” Distinguishing and tracking grievances related to access allows the state to better identify and address issues in timely access to LTSS (Killingsworth 2016). Similarly, **Texas** requires plans to report grievances data according to detailed subcategories that can be used to examine member reported access issues in detail. Box III.D.5 below provides a few examples.

Box III.D.5 Texas’s access-related subcategories of grievances

Texas requires plans to report grievances data according to the following access-related subcategories:

- Appointment Availability: For grievances related to ability to access an appointment in a timely manner within contractual requirements for an in-network provider
- Authorization Issue: For grievances related to the delay of services due to concerns with authorization
- Continuity of Care: For grievances related to the disruption of authorized services
- Discharge from Facility: For grievances related to the disagreement with a member’s release from facility
- Home Health: For grievances related to home health services
- Home or Auto Modifications: For grievances related to issues with the delay of installation of home or auto modifications
- Travel Time/Availability/Distance: For grievances related to the length of time and distance required to access services
- Other: Used when the issue does not relate to any other Access to Care subcategories

Source: State of Texas Medicaid and CHIP – Uniformed Managed Care Manual. Member and provider complaints text file layout.xls. Available at <https://www.hhs.texas.gov/services/health/medicaid-chip/managed-care-contract-management/texas-medicaid-chip-uniform-managed-care-manual>.

Accessed January 14, 2022.

As discussed in Chapter II, some states also use grievances as an important source of information on the performance of MLTSS plans. Several states, such as **Florida** and **Idaho**, have established grievance tracking systems (sometimes referred to as complaint tracking systems) that enable them to analyze this information:

The **Florida** Agency for Health Care Administration (AHCA) operates a hub that compiles grievances from a variety of sources, including those submitted through the state website, toll-free number, MLTSS plans, Aging and Disability Resource Centers, and the ombudsman. AHCA monitors this hub continuously to address individual issues and to identify systemic issues across MLTSS plans or providers.

Idaho has established a complaint monitoring system that the state uses to track issues in real-time. The system includes a universal, public-facing dashboard where anyone can submit an issue or complaint that is then routed to the state’s triage team and Complaint Intake Managers, who prioritize and manage all submitted complaints. MLTSS plans have user roles in the system so that they can view and manage complaints related to their plan in the system. In addition, using data from this system, the state can identify complaints that may indicate systemic issues or issues specific to one of the state’s two MLTSS plans—which enables state staff to request further information from the plan. The state also uses the data coming from the system to provide feedback to MLTSS plans in monthly monitoring reports (for example, on the timeliness of plan resolution of complaints and trends in complaint categories by plan). If MLTSS plans do not resolve complaints logged in the system within 3 business days for high priority complaints and 10 business days for all other complaints, the state will monitor the area of concern and may apply a fine or withhold a portion of the monthly capitation rate for plans that exceed a certain threshold of complaints or critical incidents, or that do not resolve them according to contractually specified time frames. To validate information on grievances or appeals received through the grievance monitoring system, during on-site audits, state staff review notices distributed by the plans, customer service line recordings, case management notes, and other sources of data.

Using grievances and appeals data to validate plan-submitted reports

Florida collects detailed missed services reports from its MLTSS plans monthly (see Box III.D.5). The state uses its complaint hub (described above) to validate plan-reported information. For example, AHCA compares the missed services reports that plans submit to complaints about missed services submitted via the hub to discern if the report and complaints are identifying similar issues. Both sources of information help AHCA identify potential systemic access issues and inform weekly calls with MLTSS plan contract managers (Libersky et al. 2019).

Box III.D.6: Florida’s Missed Services Report—Data Elements

Each month, Florida’s collects the following information on all MLTSS enrollees that miss a service:

- Enrollee Last Name
- Enrollee First Name
- Medicaid ID
- Region
- County Of Residence
- Service Provider Name
- Authorized Service Type
- Number of Authorized Service Units Per Day
- Number of Missed Service Units Per Day Missed
- Percent of Authorized Service Units Per Day Missed
- Date of Missed Service
- Date MCP Notified of Missed Service
- Date of Services Resumed
- Reason for Missed Service
- Resolution of Missed Service
- Comments

Source: State of Florida, Agency for Healthcare Administration. “Missed Services Report Summary.” n.d. Available at https://ahca.myflorida.com/medicaid/statewide_mc/report_guides/msr.shtml. Accessed August 22, 2021.



Additional resources

For more information on Electronic Visit Verification systems and requirements, see MACPAC's 2019 Fact Sheet: [Electronic Visit Verification for Personal Care Services: Status of State Implementation](#).

For more information on using grievances and appeals data for monitoring and oversight activities, see CMS's 2019 report: [Critical Incidents, Grievances, and Appeals: Data to Support Monitoring and Evaluation of Medicaid Managed Long Term Services and Supports \(MLTSS\) Programs](#).

E. Health and welfare

Federal and state requirements

As discussed in Chapter I, CMS requires states that deliver HCBS through 1915(c) waivers to implement systems to identify, address, and seek to prevent instances of abuse, neglect, exploitation, and unexplained death—events referred to as critical incidents. These systems must be able to achieve three key objectives through six key functions (see Box III.E.1). State MLTSS programs that operate under other federal authorities are held to similar standards and assurances.

Contract provisions to support state oversight

States with MLTSS programs typically meet these federal requirements by defining in their contracts or other policy and procedural documents (1) the types of incidents that MLTSS plans or providers must report; (2) the entity or entities with whom the plan or provider must file incidents; (3) the timeliness for reporting; (4) whether the MLTSS plan, provider, and/or state are responsible for conducting reviews/investigations; (5) processes and time frames for conducting reviews/investigations; (6) required actions pending a review or investigation; and (7) any monitoring processes required for the plan and/or conducted by the state to ensure that policies and procedures related to critical incidents are being followed (Libersky et al. 2019).

As discussed in Chapter II, there is no standardized, federal definition of critical incident, which results in definitions that vary across states and, in some cases, across programs within the same state (CMS 2020b). A CMS survey conducted in July 2019 found that critical incident reporting categories in most states lacked both differentiation and specificity (CMS 2020b).



Chapter III, section E at a Glance

- States ensure the health, safety, and welfare of MLTSS enrollees by establishing incident management systems to track critical incidents (including abuse, neglect, exploitation, and unexplained death) and taking appropriate remediation and system improvement action.
- States can improve their ability to use critical incident data by adopting consistent definitions of these incidents across programs.
- Key data sources and methods for monitoring critical incidents include analyzing plan submitted reports, utilizing internal critical incident tracking systems to identify these incidents timely, and conducting audits. Electronic visit verification also holds promise as a means of monitoring health and welfare.

To improve reporting, CMS encourages states to create consistent definitions of types of critical incidents in contracts with MLTSS plans to reduce ambiguity and inaccurate reporting (CMS 2020b; Libersky et al. 2019). These definitions would help states better track and respond to incidents and identify systemic issues. Box III.E.1 includes an excerpt of **Tennessee’s** contract language regarding home health agency critical incident reporting, including the definition of critical incidents.

Box III.E.1: Tennessee Contract Requirements for Home Health Agency Critical Incident Reporting

“The CONTRACTOR shall identify, track, and review all significant critical incidents that occur during the provision of Home Health (HH) services... A HH critical incident shall include those significant incidents that are reported to the CONTRACTOR from the Home Health Agency (HHA). Critical incidents include, but are not limited to, the following:

Any unexpected death, regardless of whether the death occurs during the provision of HH; Major/severe injury; Safety issues; Suspected physical, mental or sexual abuse; Neglect; Life-threatening medical emergency; Medication error; Financial exploitation; Theft.

Each incident event must be reported using the TENNCARE prescribed HHA Critical Incident report template within twenty-four (24) hours of detection or notification by the CONTRACTOR’s QM/QI Program staff receiving information relative to such an incident. An updated report, including results of investigation and next steps must be submitted to TENNCARE within thirty (30) calendar days of notification of the incident.

The CONTRACTOR shall, as part of its critical incident management system, track, review and analyze critical incident data that takes into consideration all incidents occurring for members supported by an agency, that occur during the provision of HH services, including the identification of trends and patterns, opportunities for improvement, and actions and strategies the CONTRACTOR will take to reduce the occurrence of incidents and improve the quality of HH services received.”

Source: State of Tennessee, Division of Health Care Finance and Administration, Bureau of TennCare. “Statewide MCO Contract with Amendment 14.” July 2021. Available at <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>. Accessed August 6, 2021.

State monitoring strategies

Analyzing plan reports

State Medicaid and CHIP agencies can contractually require critical incident reporting on an ongoing basis as part of its monitoring and oversight of critical incident systems. **Idaho** requires its MLTSS plans to submit quarterly Critical Incident Resolution Reports in Excel, which document the assigned priority levels for each critical incident, enrollee information, and response time frames and details. The report also includes a summary indicating (1) the total number of critical incidents received; (2) the percent of critical incidents relating to abuse, neglect, and exploitation; (3) the time frame for the disposition/resolution of critical incidents; (4) the number and percent of critical incidents for which the MLTSS plan did not meet the specified time frame for resolution; and (5) identification of any trends regarding critical incidents and any action taken to address these trends (Idaho Department of Health

and Welfare, 2016). If critical incidents are not resolved in the time frame required, the state Medicaid agency will initiate a Focused Monitoring of the area of concern. Continued non-compliance can result in payment reductions to the plan.

Florida built critical incident monitoring into an existing adverse event reporting system for hospitals. The state reviews all critical incident data to identify whether the incident was reported correctly and submitted timely; if it occurred in the community or a facility; whether suspected incidents of abuse, neglect, or exploitation were reported to Adult Protective Services; and whether preventative measures were taken and appropriate follow-up was provided to the enrollee. State staff also review incidents to determine whether those related to the quality of care rendered by a licensed provider should be referred to the Division of Health Quality Assurance for investigation. Each incident is reviewed by a member of the Case Management Unit staff and a supervisor, as well as the plan's contract manager.



Additional resources

For more information of incident management systems, see these Center for Medicare & Medicaid Services presentations:

- [Findings from the 1915\(c\) Waiver Incident Management Survey: Incident Management Systems and Processes](#)
- [Incident Management in 1915\(c\) Waiver Programs: Incident Management Recommendations](#)

For more information on how to critical incident data for monitoring and oversight activities, see CMS's 2019 report: [Critical Incidents, Grievances, and Appeals: Data to Support Monitoring and Evaluation of Medicaid Managed Long Term Services and Supports \(MLTSS\) Programs](#).

Tracking critical incident data

Automated systems can be an effective tool for collecting and storing critical incident reports. These systems also allow for real-time data access for multiple parties and can support interoperability. In its MI Choice program, **Michigan** uses a Critical Incident Reporting System that gives HCBS waiver agencies real-time access to critical incidents when they occur and are being resolved (Michigan Department of Health and Human Services 2017). The state Medicaid agency uses the data reported to review, evaluate, and trend the incident reports, and it conducts an analysis of plan-reported remediation strategies (Michigan Department of Health and Human Services 2017). In addition, **Kansas** has implemented its Adverse Incident Reporting database to capture critical incidents. The database is available via a public link, which providers and individuals can use to report adverse/critical incidents, to ensure the health and safety of enrollees (KanCare 2018). Each reported incident is assigned to a Program Integrity employee at the state Medicaid agency, and MLTSS plans can view and report on the remediation progression of each incident linked to that plan (Kansas Department for Aging and Disability Services 2018). **Idaho's** grievance tracking system captures critical incidents in real-time. If MLTSS plans do not resolve grievances logged in the

system within 3 business days for high priority grievances (including critical incidents), the state will initiate a focused monitoring of the area of concern and may apply fines or withhold a portion of the monthly capitation payment.

In addition, states can use robust critical incident data to develop outcome-based performance measures that assess the health and welfare of enrollees (CMS 2020b). For example, in **New Jersey**, MLTSS plans are required to report critical incident data into the Social Assistance Management System (SAMS) system, a database managed by the Division of Aging (DoAs). DoAs uses SAMS to track and trend critical incident activity. MLTSS plans must report “performance measure 18,” which captures the number of critical incidents by category for the reporting period as well as timeliness of reporting, and MCO findings/interventions. Measures are also reviewed by the Division of Medical Assistance and Health Services (DMAHS) and validated by EQROs as part of their annual review.

Table III.E.1 provides additional examples of performance measures related to health and welfare/ critical incidents that are used by states.

Table III.E.1. Example health and welfare/ critical incidents performance measures

State	Measure
Florida	Percentage of recipients who received telephone contact at least monthly to assess their health status, satisfaction with services and any additional needs.
	Percentage of health, safety and welfare issues reported to the Agency in adverse incident reports within twenty-four (24) hours of the incident.
	Percentage of recipients with substantiated reports of abuse, neglect or exploitation that had appropriate follow-up by the MLTSS plan.
	Percentage of recipients with reports of the use of prohibited restraints, whose investigations started within twenty-four (24) hours of being reported to Adult Protective Services (APS).
	Percentage of health status and service concerns that were addressed by the MLTSS plan.
Illinois	Number and percentage of waiver participants with reports of critical incidents other than abuse, neglect, or exploitation that the MLTSS plans reviewed and took corrective measures to remedy.
Kansas	Number of participant-reported critical incidents that were initiated and reviewed within the time frames specified in the waiver.

Sources:

State of Florida, Agency for Health Care Administration. “2018-2023 Model Health Plan Contract, Exhibit II-B – Long Term Care (LTC) Managed Care Program.” September 1, 2021. Available at https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2021-10-01/Exhibit_II_B_LTC_2021-10-01.pdf.

State of Illinois, Department of Healthcare and Family Services. “MCO Contract.” 2018. Available at <https://www.illinois.gov/hfs/SiteCollectionDocuments/2018MODELCONTRACTadministrationcopy.pdf>.

State of Kansas KenCare Program. “Medicaid State Quality Strategy.” September 2014. Available at https://www.kancare.ks.gov/docs/default-source/about-kancare/history-of-kancare/attachment_j_state_quality_strategy.pdf?sfvrsn=9464b1b.

TN Division of TennCare 2021 Update to the Quality Assessment and Performance Improvement Strategy. Accessed 12/28/2021. Available at <https://www.tn.gov/content/dam/tn/tenncare/documents2/2021UpdateQualityImprovementStrategy.pdf>.

Service plan audits and analysis of electronic visit verification data

New Jersey described that as part of their annual review, EQROs conduct service plan audits for a sample of each plan's HCBS and nursing facility population that include components focused on critical incident education, reporting, and remediation. As a part of the audit, the EQRO assesses whether there is required documentation that: (1) the Care Manager reviewed with the member the process for immediately reporting any gap in service delivery (such as a missed visit), (2) that the care manager explained to the member the process for reporting a critical incident, and (3) for members with a reported gap in service, there is documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service. New Jersey also shared that the state is working to operationalize using EVV to track and trend gaps in care and how they relate to reported critical incidents.

F. Cultural competency and physical accessibility

Federal and state requirements

42 C.F.R. §§ 438.206 and 457.1230(a) require that MLTSS plans participate in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees—including those with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities—regardless of sex. In addition, federal regulations require that plans ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid and CHIP enrollees with physical or mental disabilities.

Federal regulations at 42 C.F.R. §§ 438.68 and 457.1218 require that states develop network adequacy standards that align with requirements around cultural competency and physical accessibility. Specifically, they must consider the ability of providers to communicate with limited English proficient enrollees in their preferred language and ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid and CHIP enrollees with physical disabilities, intellectual or developmental disabilities, and mental health and substance use disorders (MH/SUD).

Contract provisions to support state oversight

Most state Medicaid and CHIP agencies require that MLTSS plans develop and implement comprehensive cultural competency plans, which often describe how they will monitor language services provided, among other topics. MLTSS plans are expected to identify and address deficiencies and describe the results of annual evaluations, if plans conduct them, and detail any interventions to be implemented. For example, **Hawaii's** MLTSS contracts describe specific requirements for the development and implementation of Cultural Competency plans (see example contract language in Box III.F.1).



Chapter III, section F at a glance

- To meet requirements at 42 C.F.R. § 438.206 related to cultural competency, many states develop and implement Cultural Competency Plans that include details on monitoring and oversight of culturally competent services and supports.
- Some states require that plan provider directories also include information on cultural competency trainings that provider have completed.
- To address physical accessibility, states require plans to meet the accessibility requirements of the Americans with Disabilities Act and may require plans to submit accessibility compliance plans.
- State may use the following strategies to ensure cultural competency and physical accessibility:
 - Utilizing consumer experience surveys to understand the enrollee experience with the cultural competency and physical accessibility of services provided by managed care plans.
 - Conducting accessibility checks or on-site accessibility surveys.
 - Assigning a specific staff person to implement and monitor the cultural competency program.
 - Reviewing provider directories.
 - Reviewing plan reports and grievances data.

Box III.F.1: Hawaii's contract requirements for cultural competency plans

"The Health Plan shall have a comprehensive written cultural competency plan that shall:

1. Design programs, interventions, and services, which effectively address cultural and language barriers to the delivery of appropriate and necessary health services, and address cultural disparities identified via the Disparities Report in § 5.1.B.1.e.10;
2. Describe how the Health Plan will ensure services are provided in a culturally competent manner to all Members so that all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, understand their condition(s), the recommended treatment(s), and the effect of the treatment on their condition, including side effects;
3. Describe how the Health Plan will effectively provide services to enrollees of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the individual Members and protects and preserves the dignity of each... (State of Hawaii 2020, Contract)."

Source: State of Hawaii Department of Human Services. "Request for Proposals (RFP) QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals." RFP-MQD-2021-00.8 December 2020. Available at https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/RFP/quest-integration/QI_RFP-MQD-2021-008_Amendments_1-4.pdf. Accessed August 6, 2021.

The Community Living Policy Center at Brandeis University has identified ten key contract elements they deem especially important to include in contracts with MLTSS plans to improve plan and provider capacity to accommodate beneficiaries with disabilities and promote cultural competency. For example, they suggest requiring that managed care plans assign a specific person responsible for overseeing plan and provider actions aimed at achieving physical and programmatic accessibility of facilities and services and that plans carry out an on-site accessibility survey of provider facilities that includes availability of accessible medical equipment such as exam tables and weight scales, and a requirement that these surveys not be delegated to network providers to complete (Breslin, 2017). More information on these ten elements can be found in the additional information box below.

Additional information

For more information on the ten contract elements identified by the Community Living Policy Center as essential for managed care plans and providers to improve accessibility for beneficiaries with disabilities, see the University of California San Francisco Community Living Policy Center's 2017 brief: [Promoting Physical and Programmatic Accessibility in Managed Long-Term Services and Supports Programs](#).

For more information on physically accessible provider sites, see CMS's 2017 brief: [Increasing the Physical Accessibility of Health Care Facilities](#). The brief provides an overview of the importance of physical accessibility of health care facilities, outlines relevant laws, provides examples of federal and state efforts to increase accessibility, and includes suggestions for improving the physical accessibility of health care facilities.

New York's Medicaid Advantage Program contract includes detailed guidelines for MCO compliance with the Americans with Disabilities Act. The guidelines include the contract standard, suggested methods for compliance, and requirements for a compliance plan submission on the topic. Box III.F.2 below includes an example of contract standards.

Box III.F.2: Examples of New York contract requirements for accessibility

Standard for Compliance: Member Services sites and functions will be made accessible to, and usable by, people with disabilities.

Suggested Methods for Compliance (include, but are not limited to those identified below)

1. Exterior routes of travel, at least 36" wide, from parking areas or public transportation stops into the MCO's facility
2. If parking is provided, spaces reserved for people with disabilities, pedestrian ramps at sidewalks, and drop-offs
3. Routes of travel into the facility are stable, slip-resistant, with all steps > ½" ramped, doorways with minimum 32" opening
4. Interior halls and passageways providing a clear and unobstructed path or travel at least 36" wide to bathrooms and other rooms commonly used by enrollees
5. Waiting rooms, restrooms, and other rooms used by enrollees are accessible to people with disabilities
6. Sign language interpreters and other auxiliary aids and services provided in appropriate circumstances
7. Materials available in alternative formats, such as Braille, large print, audio tapes
8. Staff training which includes sensitivity training related to disability issues [Resources and technical assistance are available through the NYS Office of Advocate for Persons with Disabilities - V/TTY (800) 522-4369; and the NYC Mayor's Office for People with Disabilities - (212) 788-2830 or TTY (212)788-2838]
9. Availability of activities and educational materials tailored to specific conditions/illnesses and secondary conditions that affect these populations (e.g. secondary infection prevention, decubitus prevention, special exercise programs, etc.)
10. MCO staff trained in the use of telecommunication devices for enrollees who are deaf or hard of hearing (TTY/TDD) as well as in the use of NY Relay for phone communication
11. New enrollee orientation available in audio or by interpreter services
12. Policy that when member services staff receive calls through the NY Relay, they will offer to return the call utilizing a direct TTY/TDD connection

Source: State of New York. Medicaid Advantage Plus Model Contract. 2017. Available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/docs/2017-2021-map_model_contract.pdf. Accessed February 18, 2022.

State monitoring strategies

Analyzing consumer experience of care surveys and plan reports

Many states require MLTSS plans to conduct experience of care surveys with enrollees and providers, as well as on-site surveys, to assess cultural competency and accessibility.

For example, MLTSS plans participating in the Senior Care Options program in **Massachusetts** must administer an annual survey or focus group with non-English-speaking enrollees, enrollees with physical disabilities, and enrollees from a minority ethnic group served by the plan to assess if the MLTSS plan's providers are providing culturally competent and accessible services and supports (see Box III.F.3) (Commonwealth of Massachusetts 2015, Senior Care Options contract, Section 2.10.F). Plans may decide which survey to use. Massachusetts state staff noted that to be most informative for oversight of MLTSS plan performance, survey data should be able to be stratified by product rather than aggregated across all enrollees in the plan's parent organization (for example plans that serve both Medicare-only and Medicare-Medicaid enrollees.)

Tennessee's MLTSS plans must contribute to the state Medicaid agency's surveys on health disparities. Section A.2.30.22.4 of Tennessee's MLTSS contracts specify that MLTSS plans conduct surveys annually online over a 10-week period, and the survey results are published on TENNCARE's website (State of Tennessee, Statewide MCO Contract 2021). **Idaho** conducts annual consumer experience surveys and surveys providers for cultural competency standards.



Additional resources

There are relevant questions for assessing cultural competency and accessibility in some nationally standardized surveys. For example, the [National Core Indicators Aging and Disabilities](#) (NCI-AD) includes the following indicators:

- Percentage of people who have access to information about services in their preferred language
- Percentage of people who have needed home modifications
- Percentage of people who have needed assistive equipment and devices

Box III.F.3: Massachusetts's enrollee survey

Massachusetts Senior Care Option's (SCO) program contract section 12.10.F requires MLTSS plans to administer annual surveys to certain enrollee populations. Specifically, their contract requires each plan to "administer an annual survey to all Enrollees and report the results to EOHHS [the state Medicaid agency] on the anniversary of the start date of the Contract." Quality Management projects based on the findings must be developed and reported to EOHHS. As part of its measurement, the Contractor must conduct one survey or focus group with each of the following groups:

- Non-English-speaking Enrollees to assess their experience with the Contractor's ability to accommodate their needs
- Persons with physical disabilities to assess their experience with the Contractor's ability to meet their needs

- Enrollees from a minority ethnic group served by the Contractor to assess their experience with the Contractor's ability to provide culturally sensitive care and support to family members and care givers of Enrollees."

Source: Commonwealth of Massachusetts MassHealth Office of Long-Term Services and Supports of the Executive Office of Health and Human Services. "MASSHEALTH Senior Care Options Contract for Senior Care Organizations by and Between The Executive Office of Health and Human Services and [TBD]." 2015. Available at <https://www.integratedcareresourcecenter.com/sites/default/files/Massachusetts%20D-SNP%20contract%20and%20app%202015.pdf>. Accessed August 6, 2021.

Conducting accessibility checklists and on-site accessibility surveys

California requires its MLTSS plans to conduct a "Facility Site Review Tool" as a checklist to assess physical accessibility elements at primary care provider sites and all provider sites that serve a high volume of older adults and people with intellectual or developmental disabilities. Plans must make the results of the facility site review tool publicly available on the plan website and through provider directories (State of California, 2012). MLTSS plans must submit annual reports that explain the benchmarks used to identify high-volume providers subject to this requirement (Lipson et al. 2017).

Assigning state staff to implement and monitor a cultural competency program

States can also ensure that cultural competency requirements are met by designating a state staff person to monitor compliance. **Arizona** requires that plans have a specific position, a Cultural Competency Coordinator, for the implementation and monitoring of the cultural competency program and plan (AHCCCS 2020, Section D.15). Similarly, **New Jersey's** MLTSS contract includes requirements for a Cultural and Linguistics Services Plan. Plans are required to address the following topics at a minimum: physical and communication access, twenty-four-hour interpreter access, requirements for assessing the linguistic and cultural needs of enrollees who speak a primary language other than English, and resolution of cultural issues (see Box III.F.5 for additional details). The MLTSS plan must also identify an individual who is responsible for the implementation and oversight of the plan (State of New Jersey 2021, Section 5.14).

Box III.F.5: New Jersey's cultural and linguistic services plan

New Jersey's MLTSS contract (Section 5.14) requires that "the Contractor shall address the relationship between culture, language, and health care outcomes through, at a minimum, the following Cultural and Linguistic Service requirements:

- **Physical and Communication Access.** The Contractor shall provide documentation regarding the availability of and access procedures for services which ensure physical and communication access to: providers and any Contractor related services (e.g. office visits, health fairs); customer service or physician office telephone assistance; and, interpreter, TDD/TT [telecommunications devices for the deaf/text telephone] services for individuals who require them in order to communicate. Document availability of interpreter, TDD/TT services. The Contractor shall make oral interpretation services available free of charge to each enrollee and potential enrollee.

- **Twenty-four (24)-Hour Interpreter Access.** The Contractor shall provide twenty-four (24)-hour access to oral interpreter services free of charge for all enrollees/potential enrollees including the deaf or hard of hearing at provider sites within the Contractor’s network, either through telephone language services or in-person interpreters to ensure that enrollees are able to communicate with the Contractor and providers and receive covered benefits. The Contractor shall identify and report the linguistic capability of interpreters or bilingual employed and contracted staff (clinical and non-clinical). The Contractor shall provide professional interpreters when needed where technical, medical, or treatment information is to be discussed, or where use of a family Member or friend as interpreter is inappropriate. Family Members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical. The Contractor shall provide for training of its health care providers on the utilization of interpreters...
- **Group Needs Assessment.** Contractor shall assess the linguistic and cultural needs of its enrollees who speak a primary language other than English. The findings of the assessment shall be submitted to DMAHS [Division of Medical Assistance and Health Services] in the form of a plan entitled, “Cultural and Linguistic Services Plan” at the end of year one of the contract. In the plan, the Contractor will summarize the methodology, findings, and outline the proposed services to be implemented, the timeline for implementation with milestones, and the responsible individual. The Contractor shall ensure implementation of the plan within six months after the beginning of year two of the contract. The Contractor shall also identify the individual with overall responsibility for the activities to be conducted under the plan. The DMAHS approval of the plan is required prior to its implementation...
- **Resolution of Cultural Issues.** The Contractor shall investigate and resolve access and cultural sensitivity issues identified by Contractor staff, State staff, providers, advocate organizations, and enrollees.”

Source: State of New Jersey, Department of Human Services. “Contract Between State of New Jersey, Department of Human Services, Division of Medical Assistance and Health Services and ____ Contractor.” January 2021. Available at <https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>. Accessed January 18, 2022.

Reviewing provider directories

Provider directories are required to include information on the cultural and linguistic capabilities of providers and physical accessibility accommodations of facilities, as specified by 42 C.F.R. §§ 438.10(h) and 457.1207; they may also include information on cultural competency trainings that providers have completed. States must ensure that plans include this information and the availability of providers with specific language, cultural, or physical accessibility characteristics.

Reviewing plan compliance reports and grievances data

States can review plan reports on compliance with cultural competency and physical accessibility requirements. **Tennessee** requires plans to submit two such reports, described in Box III.F.6 below.

Box III.F.6: Tennessee’s Non-Discrimination Compliance Report and Language and Communication Assistance Report

“2.30.22.3 The CONTRACTOR shall submit a quarterly **Non-discrimination Compliance Report** which shall include the following:

- 2.30.22.3.1 A summary listing that captures the total number of the CONTRACTOR’s new hires that have completed civil rights/nondiscrimination training and cultural competency training and the dates the trainings were completed for that quarter; and
- 2.30.22.3.1.1 A listing of the total number of the CONTRACTOR’s employees that have completed annual civil rights training and cultural competency training and the dates completed for that quarter, if annual training was provided during that quarter.
- 2.30.22.3.2 An update of all written discrimination complaints filed by individuals, such as, employees, members, providers and subcontractors in which the discrimination allegation is related to the provision of and/or access to TennCare covered services provided by the CONTRACTOR, which the CONTRACTOR is assisting TENNCARE with resolving.

2.30.22.3.3 **The language and communication assistance report** shall capture a summary listing of the language and alternative communication services that were requested by the members (i.e. Arabic; Braille) and the method used to provide the language and alternative communication service to the members (i.e. interpretation; translation). In addition, the report shall contain a listing of the number of LEP [limited English proficient] members that are enrolled in the MCO [managed care organization] broken down by county and the languages that are spoken by these members. Upon request the CONTRACTOR shall provide a more detailed report that contains the member’s identification number, the requested service, the date of the request, the date the service was provided and the name of the service provider.”

Source: State of Tennessee. “Tennessee’s Statewide MCO Contract with Amendment 14.” July 2021. Available at <https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>. Accessed August 6, 2021.

Grievances are an important way for beneficiaries to raise issues with services received, the timeliness of authorization decisions, or other issues (such as those related to interpersonal interactions with plan or provider staff including related to cultural competency or accessibility). State Medicaid and CHIP agencies are encouraged to consider existing trends in grievances when developing and refining their cultural competency requirements for MLTSS plans, and include requirements that address deficiencies in those plans. State and Medicaid and CHIP agencies should also ensure that grievances related to interpreter services, physical access, reasonable accommodations, and accessible equipment are categorized with sufficient detail to enable their identification for analysis. Beneficiaries can submit grievances or written discrimination complaints related to availability of and access to culturally competent care, and MLTSS plans must then investigate and resolve the issues, as necessary.

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Acknowledgements

The authors would like to acknowledge the contributions of several individuals to the preparation of this toolkit. We wish to thank the Center for Medicare & Medicaid Services' Division of Managed Care Policy project officers Angela Jones and Alexis Gibson, Amy Gentile, and the rest of the Center for Medicaid and CHIP Services' Medicaid Managed Long Term Services and Supports work group that provided review and input into this toolkit. At Mathematica, we thank our colleagues Matthew Mariani for toolkit template design and production assistance, and Susan Gonzales for editorial assistance.

We also would like to thank the many state Medicaid agency staff who generously gave their time and shared their knowledge and resources, including Chris Barrott and Ali Fernández from Idaho; Rachel La Croix, Melissa Vergeson, Paula James, Logan Harrison, Savetra Robinson, and Kristin Sokoloski from Florida; Frank Genco, Michelle Erwin, Kathi Montalbano, Denbigh Shelton, Jimmy Perez, Soila Villarreal, Eva Valencia, Camisha Banks, and Sylvia Salvato from Texas; Matthew Behrens, Elizabeth Smith, Laura Boutwell, Jeanette Trestrail and Jason Rachel from Virginia; and Akanksha Kapoor, Carol Grant, Joe Vetrano, Neha Chopra, Carolyn Nasson, Statira Ziemba, Marc Gonzer, and Hope Morante from New Jersey.

This toolkit was created as part of a contract between Mathematica and the Center for Medicare & Medicaid Services that provides technical assistance to states on Medicaid managed care program design, operations, and management. Questions and requests related to the content presented in this toolkit may be submitted to ManagedCareTA@mathematica-mpr.com.



Promoting Access in Medicaid and CHIP Managed Care:

Managed Long-Term Services and Supports Access Monitoring Toolkit

June 2022

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Submitted to:

Division of Managed Care Policy
Center for Medicaid and CHIP Services
Center for Medicare & Medicaid Services
Baltimore, MD
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Contract/Task Number: HHSM-500-2010-00026I/HHSM-500-T0011

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Suggested citation: Lester, Rebecca S., Jenna Libersky, Alena Tourtellotte, Rachel Gringlas, Samantha Zepeda, and Debra Lipson. "Promoting Access in Medicaid and CHIP Managed Care: Managed Long-Term Services and Supports Access Monitoring Toolkit." Baltimore, MD: Division of Managed Care Policy, Center for Medicaid and CHIP Services, Center for Medicare & Medicaid Services, U.S. Department of Health and Human Services, 2022.

