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IssueBRIEF

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Measuring Up: A Novel Approach to Assessing State Oversight of Medicaid Managed Care

About Managed Care

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OVERVIEW

States can deliver Medicaid services to people through a number of models, one of which involves contracts with managed care organizations (MCOs) to provide Medicaid benefits to people in exchange for a monthly payment from the state. In 2012, 36 states and the District of Columbia contracted with MCOs, which covered nearly 75 percent of the 57 million Medicaid beneficiaries nationwide.[1]

States that contract with managed care plans must demonstrate to a variety of stakeholders, including the Centers for Medicare & Medicaid Services (CMS), that the state Medicaid agency is appropriately overseeing the plans. This includes monitoring enrollees' access to care as well as the quality and cost of services. However, there are no recognized standards for what constitutes sufficient monitoring, which has hindered efforts to assess the effectiveness of state oversight. This brief describes a novel approach that Mathematica Policy Research used to evaluate state oversight of a new Medicaid managed care program for individuals with disabilities in Washington State.

THE IMPORTANCE OF MONITORING MANAGED CARE

In contrast to a fee-for-service (FFS) arrangement, in which states pay providers directly, contracting with MCOs requires that states oversee the accessibility, quality, and cost of the services that plans provide. Such oversight is critical to protecting the public's investment in high quality Medicaid services and to supporting the health and safety of vulnerable members of our society.[2] In other words, states must conduct oversight to ensure they get what they pay for.[3]

A STATE'S ROLE IN MONITORING MANAGED CARE

State oversight typically involves gathering information on plan performance and quality, analyzing the information, and using the findings to improve the program (see Figure 1 for examples of each activity). The information that states gather includes lists of providers and facilities in the plan's network; reports of complaints, appeals, and grievances filed with the plan; measures of quality and performance; and data from individual service claims, known

State process for overseeing Medicaid managed care plans

Gather information	Analyze data and identify problems	Improve performance
Provider network lists	Map providers to determine geographic access, and conduct "mystery shopper" calls with providers to verify availability	Suspend auto-assignments to plans with provider shortages above a maximum threshold
Educational materials for members	Review materials for accuracy, literacy levels, and accessibility for people with disabilities	Specify needed revisions, and require distribution of revised materials to all members
Reports of appeals, grievances, and critical incidents	Identify patterns across plans, regions, and employee groups, and investigate incidents not yet resolved and delays in processing appeals	Modify contract provisions to clarify service requirements and to ensure access and quality
Quality measures	Compare scores to national benchmarks, state averages, and prior years, and identify high and low performers	Require low performers to complete performance improvements projects
Encounter records	Monitor compliance with timely reporting, and conduct validation tests to verify accuracy and completeness of data	Apply penalties for repeated failure to meet standards for accuracy, completeness, and timeliness

Figure 1

as encounter records. State officials then look for patterns and outliers in the data that may indicate access and quality problems among particular managed care plans, regions, or service types. Nearly all states also conduct surveys with a group of enrollees to understand their experiences with the plans. With the knowledge gained from this monitoring, states can discuss problems with managed care plans, conduct follow-up investigations, take corrective action, or consider broader policy changes to improve overall outcomes.

To enhance their oversight, states should review the strengths and weaknesses of their activities on a regular basis and identify areas for improvement. CMS not only supports continual improvement but also requires states that run their Medicaid plans under a 1915(b) waiver[4] to conduct an independent assessment that, among other things, "identifies positive aspects of a state's process for monitoring the program, recommends processes in state monitoring that could be improved, and…provides a baseline for future assessment."[5] However, outside of the Medicaid regulations, which set minimum standards for all Medicaid managed care plans to meet, there are no objective criteria that could be used to assess the effectiveness of state monitoring activities.

Without such standards, the organizations that states hire to conduct independent assessments have devised a variety of approaches that have some limitations. For example, a recent assessment of a non-emergency transportation program in Kentucky[6] describes the information that the state collects to conduct monitoring and the changes made in response to its analysis. However, the assessment does not address the critical processes in between—that is, how the state analyzes the information it gathers, determines what changes to make, and takes immediate action to remedy problems or makes broader policy or program changes. In other assessments, evaluators describe the process of monitoring

and improving the plans but do not objectively evaluate whether the activities are sufficient to achieve the stated goals.[7,8,9]

Our analysis used objective and subjective information to assess the practices Washington used to monitor Apple Health. Our approach improved upon previous studies by evaluating whether the mix and intensity of monitoring activities allowed Washington to achieve its goals.

A NEW APPROACH

In spring 2014, Mathematica conducted an independent assessment of Washington State's managed care program, Apple Health, which transitioned Medicaid beneficiaries with disabilities who were previously served through a FFS model into MCOs in 2013. We used an empirical approach that went beyond simply describing monitoring activities. Specifically, we evaluated the state against two separate measures of adequacy: (1) whether Washington had the right mix and intensity of monitoring activities, compared with other states, and (2) the degree to which Washington's activities achieved the state's desired program outcomes.

Our analysis used objective and subjective information to assess the practices Washington used to monitor Apple Health. We collected data through phone interviews with staff from the state Medicaid agency, representatives from three Apple Health plans, and consumer advocacy organizations. Interviewers used semi-structured discussion guides to learn how the state organized and managed the oversight of plans serving beneficiaries with disabilities. We asked respondents about the type of monitoring conducted and the specific information collected. We also asked respondents to describe their perception of the accessibility, quality, and cost-effectiveness of health care services provided to people with disabilities before and after enrollment in Apple Health.

First, we catalogued Washington's monitoring practices and compared them with minimum federal requirements and state norms to identify oversight practices that met, exceeded, or fell short of these standards. Our approach was based on a similar method that we had used in a 2012 study of state oversight of managed long-term services and supports (LTSS) programs.[10] In that study, we systematically analyzed and categorized oversight activities into three groups:

1. Norms, or practices required by federal rules or used in most of the study states
2. Promising practices, which went beyond federal regulations, could help to improve plan performance or beneficiary outcomes, and often required more-frequent review or greater capacity or resources than are typical in most of the states
3. Caution flags, which could pose a risk to beneficiaries or to achieving program goals because they involved sporadic or cursory oversight of plan performance

Although Apple Health enrolls people with disabilities but does not cover LTSS, the principles of monitoring a managed LTSS (MLTSS) program and Apple Health are similar because both serve a vulnerable population. For both programs, oversight should be more frequent, with a focus on aspects of care important to consumers. Consequently, in our assessment of Washington's oversight of Apple Health, we compared the reported frequency and intensity of monitoring in Washington with the corresponding norms, promising practices, or caution flags identified in our 2012 study of MLTSS oversight. For each practice, we assessed whether Washington met, exceeded, or fell short of the benchmark.

Second, we quantified how respondents perceived the utility and effectiveness of monitoring practices in four domains: three that are commonly monitored in managed care programs and a fourth—enrollment processes—that is important to monitor during the transition from FFS to managed care (Figure 2). We scored perceptions of effectiveness on a three-point scale.[11] We then averaged the scores from each interview to develop a combined score for each monitoring practice.

RESULTS

We identified 11 practices that met state norms, 3 that did not, and 3 that exceeded state norms. We also identified 9 practices that were unique to Washington or were not documented in the 2012 study. From the subjective assessment, we identified 5 practices that were mostly described as positive, 5 that received mixed assessments, and 3 that were mostly described as negative. Based on these quantitative indicators, as well as measures of quality and plan switching, we made several recommendations to the Washington State Medicaid agency about improving its oversight.

Monitoring and enrollment practices assessed in Washington's Apple Health program for people with disabilities

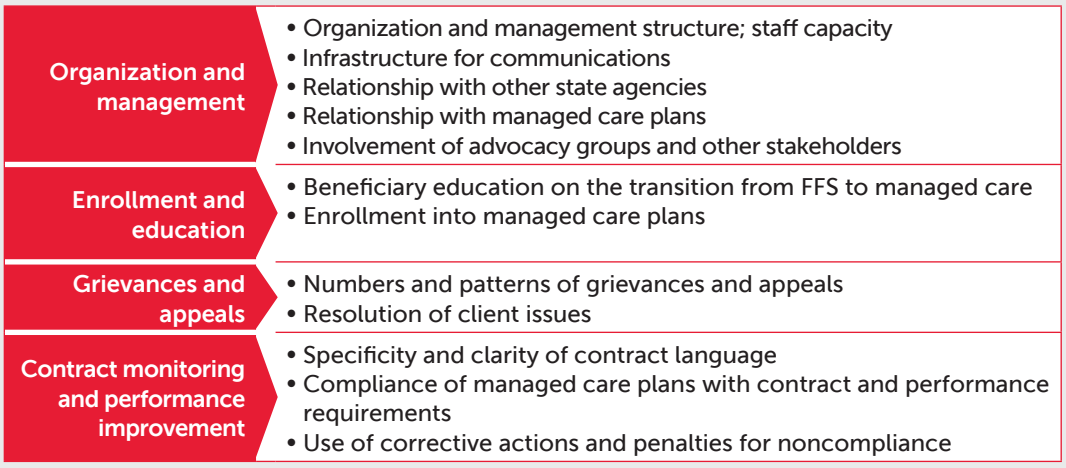

Figure 2

LOOKING AHEAD

The value of this approach to assessing managed care oversight lies in its ability to quantify practices that, in previous assessments, had been limited to qualitative descriptions. By using the results from our previous 2012 study as a set of national benchmarks against which to assess the efforts of a single state, our assessment helped Medicaid officials in Washington understand the effectiveness of their monitoring practices and how they might improve them.

The approach, however, has two important limitations. First, the norms, promising practices, and caution flags in the 2012 study were developed based on the experiences of only eight states. These states may not fully represent the frequency and intensity of activities in all states, particularly those whose Medicaid managed care plans only cover medical services. Second, the 2012 study did not capture all activities that states perform; as such, one quarter of the activities that Washington conducted could not be compared with a benchmark.

Nevertheless, applying the objective approach to additional states presents an opportunity to further strengthen the usefulness of the benchmarks in the 2012 study as well as improve states' ability to assess their oversight. By comparing the frequency and intensity of oversight practices in more states relative to the benchmarks, one could better calibrate the norms and improve their reliability and applicability to other states. Adding new practices to the existing set would also help paint a fuller picture of the range of monitoring practices used across states. Through a more comprehensive set of indicators, states can better assess the oversight of their programs and, consequently, improve the quality and value of care they provide to beneficiaries.

ENDNOTES

[1] CMS. "Medicaid Managed Care Enrollment Report." 2011. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Medicaid-Managed-Care/Medicaid-Managed-Care-Enrollment-Report.html. Accessed September 4, 2014.

[2] Fine, Janice, Patrice Mareschal, David Hersh, and Kirk Leach."Overlooking Oversight: A Lack of Oversight in the Garden State Is Placing New Jersey Residents and Assets at Risk." New Brunswick, NJ: Rutgers University, March 2014.

[3] Bergal, Jenni. "Policing Private Contractors Is Challenge for States." Stateline. Philadelphia: Pew Charitable Trusts, August 5, 2014.

[4] 1915(b) waivers are one of several options available to states that allow the use of managed care in the Medicaid Program. For more information, see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Managed-Care-1915-b-Waivers.html.

[5] CMS. "Section 1915(b) Waiver Program Independent Assessments: Guidance to States." December 22, 1998. Available at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd122298.pdf. Accessed September 2, 2014.

[6] Deloitte Consulting, LLP. "Independent Assessment of

the Kentucky Non-Emergency Medical Transportation Program: Waiver Period November 1, 2010–September 30, 2012." March 24, 2014. Available at http://chfs.ky.gov/NR/rdonlyres/1F0A9C8D-1364-4A38-A411-EE3E40A80377/0/9DeloitteNEMTAssessmentReport_dte032514.pdf. Accessed September 2, 2014.

[7] APS Health Care. "Family Care Independent Assessment: An Evaluation of Access, Quality, and Cost Effectiveness for Calendar Year 2003–2004." October 7, 2005. Available at http://www.dhs.wisconsin.gov/ltcare/pdf/FCIndepAssmt2005.pdf. Accessed October 24, 2014.

[8] Arora, Roshni Shah, Tara Bubniak, Joel Menges, and Andrea Park. "Independent Assessment of New Mexico's Medicaid Managed Care Program—Salud!" Falls Church, VA: The Lewin Group, February 16, 2007. Available at http://www.lewin.com/~/media/Lewin/Site_Sections/Publications/NMPhysicalHealthMedicaidMCOAssessment421863.pdf. Accessed September 2, 2014.

[9] California Office of State Audits and Evaluations, Department of Finance. "An Independent Assessment: California Medi-Cal Specialty Mental Health Services Consolidation Waiver." May 2002. Available at http://www.dof.ca.gov/osae/audit_reports/documents/DHS_SR_Waiver_Assmnt.pdf. Accessed October 24, 2014.

[10] Lipson, Debra, Jenna Libersky, Rachel Machta, Lynda Flowers, and Wendy Fox-Grage. "Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports." Research report no. 2012-06. Washington, DC: AARP Public Policy Institute, July 2012. Available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf. Accessed September 2, 2014.

[11] Practices described only in a positive way (for example, the respondent "liked" a practice or thought "it worked well") received a score of 3. Practices described as having both positive and negative aspects or that were undergoing improvement received a score of 2. Practices described only as negative or needing improvements not currently under way received a score of 1.

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