Spotlight

AARP Public Policy Institute

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

Lynda Flowers
AARP Public Policy Institute

Care coordination and provider network adequacy are essential components of the delivery of safe, high-quality managed long-term services and supports. Although the five interview states—Arizona, Minnesota, Tennessee, Texas, and Wisconsin—have unique approaches to ensuring managed care organizations are ready to provide care to consumers, similar themes emerged. They include the following: (a) the need for robust information technology systems; (b) the importance of partnering with contracted managed care organizations while, at the same time, conducting effective oversight; (c) the importance of some level of state involvement in care coordinator training; (d) the usefulness of benchmarks to measure network adequacy; and (e) the importance of ongoing state oversight.

Introduction

Individuals who need long-term services and supports (LTSS) depend on them to accomplish everyday tasks—bathing, toileting, dressing, preparing meals, and managing a home—that many take for granted.[1] Without this critical assistance, people who need these types of services would be unable to continue living in home and community settings and would be at risk for institutionalization.

To improve the care experience for vulnerable individuals who require LTSS while also seeking to achieve cost savings, a growing number of states are planning to launch or expand programs that provide these services to older adults and people with disabilities through contracts with managed care organizations (MCOs).[2,3] In some instances, states contract with MCOs only to provide Medicaid-financed LTSS (including home- and community-based LTSS and sometimes nursing facility care) and behavioral health services to these populations; in other instances, they combine Medicare and Medicaid financing and contract with MCOs to provide Medicare-financed primary and acute care *and* Medicaid-financed LTSS.[4] It is critical that MCOs are well prepared to provide the full range of services and supports *before* they begin enrolling vulnerable consumers, as enrollees will depend on these services for their daily living needs.

This report is the third in a series published by the AARP Public Policy Institute about implementing managed LTSS for older adults and people with disabilities.[5] We conducted interviews with Medicaid officials in five states—Arizona, Minnesota, Tennessee, Texas, and Wisconsin—to learn how each state agency determined MCO readiness to provide both care coordination services and adequate access to needed LTSS providers—a process called readiness review.[6] Summaries of interviews with

individual states may be accessed at: http://www.aarp.org/health/medicare-insurance/info-12-2013/the-readiness-review-process-AARP-ppi-ltc.html.

State officials evaluate many aspects of an MCO's ability to provide quality services through managed care. However, the scope of this report is limited to a description of how the five interview states determine whether MCOs are ready to provide care coordination and whether MCOs have contracts with adequate numbers of providers to deliver needed LTSS services.

The five interview states varied in their approach and areas of emphasis during the readiness review process. Despite these variations, common themes emerged and are presented in this report. Policy makers seeking to develop readiness review processes for care coordination and provider network adequacy through waivers, as well as through agreements with the Centers for Medicare & Medicaid Services (CMS) to participate in Financial Alignment Demonstration Projects,[7] should view this report as providing a range of examples to draw from with an eye toward what would be most useful for their program.

Characteristics of the LTSS Program in the Five Interview States

The five interview states were selected based on two factors. First, we sought to ensure geographic variation among the states interviewed. This report reflects participation from two southern states (Tennessee and Texas); two midwestern states (Minnesota and Wisconsin); and one western state (Arizona). Second, we wanted to include states with many years of experience with managed LTSS as well as those that have recently transitioned to this type of delivery system. Thus, the managed LTSS experience among the interview states ranged from 24 years (Arizona) to 3 years (Tennessee) (Table 1).

What Is Care Coordination in the Context of Managed LTSS?

In the context of this report, care coordination involves the following:

- Educating consumers (and engaged family caregivers) about a range of LTSS-related topics[8]
- Assessing consumers' physical, psychosocial, cultural, and environmental needs
- Assessing and addressing the needs of engaged family caregivers
- Determining what LTSS are needed by consumers
- Contacting LTSS service providers to ensure they understand what services are to be delivered and at what times
- Monitoring the delivery of services, including ensuring they are person and family centered
- Periodically assessing consumers (and engaged family caregivers) to determine whether their needs or preferences have changed

What Is LTSS Provider Network Adequacy?

LTSS provider network adequacy refers to the federal requirement that states ensure contracted MCOs have sufficient numbers of providers under contract so they can provide a range of LTSS to meet the needs of the enrolled population.[9] Activities associated with developing adequate networks include the following:

- Making sure the MCO has the desired number of contracted providers for each LTSS provider type (including contracting with existing LTSS providers in a community, when feasible)

Table 1
Characteristics of the Managed Term Services and Support Programs in the Five Interview States

	Program Name	Year Begun	Mandatory vs. Voluntary	Benefits Provided	Target Population	Current Enrollment	Number of Contracted Plans	Readiness Review Highlights
AZ	AZ Long-Term Care System (ALTCS)	1989	Mandatory	Medicaid primary, acute, and LTSS (including HCBS and NF); and behavioral health	Adults aged 65 and older; adults with physical disabilities and developmental disabilities; people at risk for institutionalization	25,000 older adults and adults with physical disabilities; 25,000 adults with developmental disabilities	4 plus 8 tribal contractors	State uses an extensive Readiness Assessment Tool (RAT) that assesses readiness in 13 domains
MN	MN Senior Health Options	1997	Voluntary	Medicare primary and acute; Medicaid primary, acute, and LTSS (including HCBS and 180 days of NF);behavioral health; and prescription drugs*	Adults aged 65 and older who are enrolled in Medicaid *and* Medicare Parts A and B	36,000	8	State involves a wide range of community stakeholders in the care coordination readiness process
TN	CHOICES	2010	Mandatory	Medicaid primary, acute, and LTSS (including HCBS and NF); and behavioral health	Adults aged 65 and older and all adults with physical disabilities	32,000	3	State conducts extensive roleplaying with care coordinators to ensure readiness
TX	STAR+PLUS	1998	Mandatory for adults; voluntary for children	Medicaid primary, acute, and LTSS (including HCBS); NF to be added September 2014	Adults aged 65 and older and people of all ages with disabilities	409,000 (includes people of all ages with disabilities)	5	State does scenarios testing for all operational and claims processing activities; state also does scenario testing with care coordinators to determine their readiness to provide the service
WI	Family Care	2000	Voluntary	Medicaid LTSS (including HCBS and NF)	Frail older adults aged 65 and older; adults with physical disabilities; adults with intellectual and developmental disabilities	36,898	9	State requires MCOs to describe how they will measure the quality of care coordination during the readiness review process

LTSS = long-term services and supports
HCBS= home- and community-based services
NF = nursing facility
*MN also has another fully integrated Medicare and Medicaid program called MSC+. Approximately 13,000 individuals are enrolled in that program. This project does not include a discussion of MSC+.

- Making sure contracted providers have the credentials required by federal, state, and local law
- Conducting background checks on providers when this is required
- Negotiating adequate payment rates with LTSS providers (e.g., the rate must be sufficient to support the range of activities the provider is under contract to perform)
- Making sure contracts between the MCO and the LTSS providers are fully executed
- Making sure the provider identification number(s) and payment rates are accurately loaded into the MCO's information technology (IT) system so that LTSS provider claims can be received by the MCO and paid in a timely manner

What Is Readiness Review?

Readiness review refers to the activities that state officials undertake to make sure MCOs are prepared to provide the range of contracted services *before* they begin enrolling consumers. Readiness review typically has two components: desk review and onsite review.

During desk review, MCO staff provide relevant state officials with detailed documents that outline a particular process. For example, to demonstrate readiness to provide adequate information to enrollees, an MCO might be required to submit the following documents: member handbooks; provider directories; member education materials; and examples of member notices. State officials review these materials to ensure they meet state (and, if applicable, federal) requirements, and to determine whether the processes described in the written submissions will work well when implemented at the consumer level.

> *"[Health] plan (e.g., MCO) staffing is a really big issue. It's critical that they [MCOs] have adequate staff to carry out all contract requirements, especially network adequacy … which involves finalizing all of the contracts with their [the MCO's] providers, making sure those contracts are in place. For new contractors, care coordination is the foundation. It's essential that they be well trained."*
>
> —Arizona State Official

> *"All [components] are important in their own right, but the care coordination capacities, the adequacy of the provider network, and the delivery of cost effective services are the most important."*
>
> —Wisconsin State Official

During onsite review, state officials go to the MCO's offices to observe particular processes. Officials may, for example, go on site to see for themselves whether the MCO's IT systems are functioning adequately, or to conduct interviews with care coordinators. They may also inspect the premises to ensure the MCO is prepared to conduct business in accordance with contract requirements.

Why Focus on Care Coordination and Provider Network Adequacy?

Respondents in the five interview states were quick to say that every aspect of readiness review is important, but they all stressed care coordination and provider network adequacy as essential components of delivering safe, high-quality managed LTSS.

Consumers must have access to needed LTSS from the first day they are enrolled in managed care. For this to occur, MCOs must have fully executed contracts with the range of LTSS providers required to meet consumers' basic daily needs. MCOs must also ensure contracted LTSS providers have the required skills and expertise to provide needed services.

Robust LTSS provider networks are necessary to ensure consumers will have their LTSS needs met. But access to these networks depends on trained care coordinators to ensure, among other things, consumers and engaged family caregivers receive comprehensive assessments and a care plan that identifies the appropriate set of services. Care coordinators also play an important role in arranging for services and ensuring they are delivered as ordered.

Themes

The five states varied in their approaches to readiness review and in areas of emphasis during the process. Possible explanations for the variation are (a) the length of the state's experience with managed LTSS; (b) the length of the MCO's experience with managed LTSS; and (c) the type of MCO the state was contracting with (e.g., locally developed not-for-profit MCOs versus large for-profit MCOs). It was beyond the scope of this study to evaluate the efficacy of these approaches.

Despite variation among the five interview states, several themes emerged. The themes discussed below were derived from the full interviews with state officials in the five interview states. They do not reflect AARP policy.

- **Robust information technology (IT) systems provide critical support for both care coordination functions and for ensuring adequate numbers of LTSS providers.**

Four of the five interview states—Arizona, Tennessee, Texas, and Wisconsin—noted that fully functioning IT systems play a vital role in supporting care coordination processes and adequate access to LTSS providers. Respondents in those four states described some aspect of the MCOs' IT systems as an integral part of their onsite readiness review process. MCO IT systems support care coordination by ensuring (a) enrollees' service plans are properly entered into the MCO's IT system; and (b) the system can accurately transmit the ordered services to the appropriate LTSS provider. These IT functions are essential for ensuring enrollees receive their services and supports when they need them.

> *"Providers depend on their cash flow to be able to continue services; thus, the linkage between MCOs maintaining well-functioning IT systems and adequate provider access is essential."*
>
> —Texas State Official

The MCO's IT systems also support access to services by accurately storing provider identification numbers linked to the negotiated provider payment rates and paying provider claims. Respondents emphasized the importance of MCO IT functions being fully operative and accurate before older adults and people with disabilities are enrolled. Because many LTSS providers have limited operating budgets, timely payments are critical to ensuring a stable provider base, which, in turn, helps ensure access to needed services for consumers as well as continuity of care.

Finally, respondents from Texas stressed that MCO IT systems must be able to communicate with the state's Medicaid management information system (MMIS)—the system used to determine Medicaid eligibility and enrollment. MCO IT systems must be able to identify new Medicaid LTSS enrollees in real time to avoid a delay in the receipt of needed services. To achieve this, MCOs must have IT systems that smoothly interface with states' MMIS systems. In the words of one state official from Texas: "Our [the state and the MCO's] eligibility and enrollment files have to communicate. That's a

must. They [the MCOs] must adapt their systems to the state's Medicaid [information] systems. They must be able to talk to each other."

- **Operating managed LTSS programs requires states to work in partnership with contracted MCOs.**

States are responsible for ensuring MCOs are prepared to provide high-quality care coordination and access to needed LTSS from the first day they begin enrolling vulnerable consumers. States are also responsible for ongoing oversight of MCO performance, including imposing sanctions for nonperformance. All five interview states emphasized the importance of partnering with the MCOs to help them achieve contract goals. State officials indicated that the focus of their partnerships with MCOs was on collaborative care coordinator training and supporting MCO efforts to develop their LTSS provider networks. Partnerships can help states and MCOs learn from one another as they encounter new or unanticipated situations while serving clients. According to a state official in Minnesota: "You have to partner. You can't assume that a state agency will know every little detail and how it will work out in the field. We have to work together to solve problems as they arise. We have changed, improved, and clarified our contract criteria for care coordination many times over the years as we identify new or better practices."

Working collaboratively with MCOs raises questions about whether state officials are able to maintain their objectivity and properly oversee MCO performance. State officials in Minnesota said it is possible to achieve both objectives if states have well-written contracts that clearly specify care coordination and network adequacy performance requirements *and* have dedicated staff to oversee and enforce contract provisions.[10] In addition, other external entities and groups can support state oversight efforts. States frequently contract with external quality review organizations (EQROs) to oversee aspects of their programs.[11] For example, Wisconsin uses an EQRO to monitor care coordination on an ongoing basis. States may also involve consultants, ombudsmen, and advocacy groups in oversight efforts.

According to state officials in Minnesota, state staff who conduct contract oversight should *not* be the same people who develop collaborative relationships with MCOs. Having dedicated, conflict-free staff available to engage in a partnership role gives MCO representatives confidence that they will not be penalized for bringing challenges they encounter while serving clients to the attention of state officials *before* they become problems for clients, the MCO, and the state.

- **States stay involved in care coordinator training during the readiness review process and, at varying levels, on an ongoing basis.**

According to state officials, care coordinators are responsible for many functions, including (a) conducting consumer assessments; (b) developing adequate LTSS service packages; (c) ordering client services; (d) informing consumers and engaged family caregivers about consumer-directed care;[12] and (e) teaching consumers and engaged family caregivers about estate recovery.[13] Their ability to implement critical processes and to adequately inform consumers and engaged family caregivers is critical to ensuring consumer engagement and person- and family-centered care—hallmarks of a good LTSS program. Care coordinators require thorough and ongoing training to be proficient in the range of responsibilities they are expected to fulfill.

Most of the interview states—Arizona, Minnesota, and Tennessee—are involved in care coordinator training during the beginning stages of their managed LTSS programs and, at varying levels, on an ongoing basis. They do this in a variety of ways.

For example, an official in Arizona said that "it is critical that states stay involved in care coordination training over the long term in order to ensure consistency in the approach to coordinating member care—especially where there are multiple MCOs under contract." They also said continued involvement is important for ensuring adherence to minimum care coordination requirements established by the state. The official said they accomplish this goal by directly sponsoring (and funding) quarterly training for those who supervise care coordinators. They consider this cost, as one official said, "part of effectively administering a quality long-term care program. Investment in training and education is critical to facilitating the provision of high-quality, responsive care coordination services."

State officials in Minnesota said their contracted MCOs play a major role in care coordinator training. However, they also stressed the importance of state-sponsored supplemental training. Minnesota officials said they do this by sponsoring (and funding) statewide video conferences that address aspects of care coordination. In addition, the state sponsors an annual community-based services conference at which care coordination topics are addressed. The MCOs typically pay a fee for care coordinators or their managers to attend the conference.

State officials in Tennessee were in agreement with their counterparts in Arizona and Minnesota. One official said they believe that "states should be involved in care coordination training during readiness review and for the long term." According to the Tennessee official, this sustained involvement is part of "ensuring a quality program." The official went on to say that while they expect MCOs to have comprehensive care coordinator training programs, it is also important to provide (and fund) additional training: "Periodic training gives us [the state] the opportunity to clarify any areas of concern." In addition, state officials said that state-sponsored training allows them to bring MCOs and their care coordinators "up to speed" on program changes and new policies and procedures. Examples of topics that Tennessee trains care coordinators on include consumer direction; assessing natural supports; assessing consumer risk; assessing consumer needs; and cultural competency.

"State-level training is important to assure consistency from health plan [MCO] to health plan [MCO] and to ensure that care coordinators are kept informed of the state's program goals and policy changes. We have created opportunities for health plans [MCOs] to be creative, but we also want to make sure of some level of consistency. Care coordination is the cornerstone of our programs. The care coordinator is the face of the program for our enrollees, so contact and feedback from care coordinators is important to the state in assuring that programs meet the enrollees' needs."

—Minnesota State Official

"MCO's care coordinators are the 'face of the program' to the people we serve. While we expect and require that MCOs provide comprehensive initial and ongoing training for care coordinators, the direct involvement of state leadership in MCO training efforts helps to ensure that the state's vision and expectations are clearly and consistently communicated to frontline staff, and that MCOs are prepared to deliver high-quality, person-centered support. This is part of ensuring a quality program."

—Tennessee State Official

States that engaged in care coordinator training on an ongoing basis felt it made sense for two reasons. First, Medicaid policies and procedures are continually evolving, and MCOs might not have up-to-the-minute information about these changes. Making state-designed training available to care coordinators and/or their managers is one way to quickly disseminate new information. Second, because care coordination is the central component of ensuring receipt of LTSS, these states felt a need to stay involved (at varying levels) in monitoring how well service delivery is functioning. According to an official in Minnesota: "State-level training is important to assure consistency from health plan [MCO] to health plan [MCO] and to ensure care coordinators are kept informed of the state's program goals and policy changes. We have created opportunities for health plans [MCOs] to be creative, but we also want to make sure of some level of consistency."

Because LTSS care coordinators need to be familiar with a lot of information, it makes sense for states to work with MCOs to develop and disseminate new information. In addition, as with most learning processes, refresher courses help ensure care coordinators maintain their knowledge base over time.

- **Network adequacy benchmarks help MCOs understand what is involved in developing adequate LTSS provider networks.**

Three of the interview states—Arizona, Minnesota, and Tennessee—established LTSS provider network benchmarks for MCOs to achieve before allowing them to enroll consumers. Some are more prescriptive than others. Arizona, for example, has established minimum network standards for various LTSS provider types, including nursing facilities, alternative residential settings, and home care agencies. The standards set forth the number of provider or provider entities that MCOs are required to contract with. Minnesota uses *generally accepted community standards*. These standards require that access to LTSS through MCOs be equal to, or greater than, that available in a fee-for-service (FFS) system.[14] Among the interview states, Tennessee has the most prescriptive approach, setting numerical quotas for contracted LTSS providers before MCOs can begin enrollment. In addition to benchmarks, most of the interview states set limits on the amount of time consumers may spend and the distance they may be required to travel to access facility-based LTSS providers.

Having specific network goals for MCOs to meet is one way organizations—especially those new to managed LTSS—can gain an appreciation for the range of LTSS service providers they will need to contract with. MCOs also gain a sense of what it means to have LTSS networks that are adequate in size to meet consumers' needs.

Most of the interview states recognized that it is not always possible for MCOs to achieve network targets right away, especially if the state already has a shortage of FFS LTSS providers. In such cases, according to a state official, the state requires the MCO to stop enrolling consumers until they are able to expand their existing provider networks. As a state official in Wisconsin put it: "We [state officials] closely monitor the MCO as enrollees are phased in to ensure the provider network is sufficient to meet enrollees' needs." Alternatively, like Wisconsin, states could require the MCO to allow people to go outside of the MCO's contracted provider network to receive needed services that the MCO is not able to provide through its existing network. This alternative works only if there are adequate numbers of FFS LTSS providers available to consumers.

- **MCO readiness is an ongoing process that requires continual state involvement and oversight.**

State officials in Arizona, Minnesota, Tennessee, and Wisconsin stressed that ensuring MCOs are ready to provide high-quality care coordination services and robust LTSS provider networks on day one can be challenging to achieve. This is especially the case when MCOs lack experience providing managed LTSS. Thus, these state officials stressed the importance—particularly in the early days—of state officials remaining intimately involved in oversight as MCOs begin enrolling consumers. If there are not enough care coordinators to meet consumers' needs, or there is a shortage of a certain type of LTSS provider in an area, states should suspend an MCO's enrollment privileges until the state receives assurances that the MCO is able to meet the need (as is done in Wisconsin). Alternatively, state officials noted that states and MCOs may have to work collaboratively to develop creative ways to meet consumer needs (see partnership discussion above).

States need to play a critical role both in determining the adequacy of an MCO's capacity to provide the range of needed LTSS and in determining care coordination. Based on interviews with the five study states, accomplishing these goals often requires states to balance the need for continued development and improvement in these areas against the need to ensure consumers are not at risk of harm. As a state official in Arizona said: "When we say 'readiness review,' it's really a misnomer because you have to stay very closely involved during the MCO's first year of operation, and on an ongoing basis, to conduct ongoing assessments, and to provide technical assistance when necessary." One official in Tennessee said: "While readiness review is an essential step of any successful program implementation, it is only the first step. As the program is implemented, states must remain integrally involved and must have processes in place to quickly identify and resolve any issues that may arise, as well as to monitor the MCO's ongoing compliance with contractual obligations."

"At implementation, we hold twice daily calls with each MCO, and monitor statistics such as member and provider calls and key processes such as loading new enrollment files. The frequency of calls is reduced over time as we ensure that the transition is proceeding as expected. We also monitor key aspects of the implementation through reporting, such as the volume of members for whom assessments have been completed. We receive weekly, monthly, and quarterly reports that allow us to monitor compliance on key processes and requirements, and conduct onsite audits of the MCOs' data and processes, with corrective action as needed."

—Tennessee State Official

"In the beginning you have to have a daily relationship with each plan's [MCO's] key staff. We used site visits a lot at first. Now we use monthly meeting with all plans [MCOs], annual care plan audits, quarterly video conference trainings, tracking for timeliness of assessments, contract managers oversight of compliance with [contract] requirements, communications with the ombudsman's office about complaints, appeals or calls they may be getting, lots of emails, provider complaints, analysis of encounter data, ongoing plan [MCO] reports required under the contract, work groups, and stakeholder input as well as frequent phone discussions with plans [MCOs]. Through all of this, we get a good overall picture of how they [the MCOs] operate and we pretty much know their strengths and challenges."

—Minnesota State Official

Conclusion

The states interviewed used a variety of tools to ensure MCOs have adequate LTSS provider networks and well-trained care coordinators from the first day consumers are enrolled into managed care. Among these tools are the following:

- Having specific contract requirements including, for example, contractual benchmarks that MCOs must achieve to establish provider network adequacy and requirements related to care coordination processes
- Having trained state staff to provide a critical desk review of germane documents and determine when something described on paper does not seem feasible
- Working collaboratively with MCO staff to train care coordinators and, when needed, support an MCO's efforts to identify and gain contracts with needed LTSS providers
- Having the expertise to critically examine the functions of an MCO's IT systems to ensure they can support care coordination, provider payment, and other aspects of onsite review
- Being able to require MCOs to phase in, slow down, or cease enrollment when adequate numbers of providers are not available or there are insufficient trained care coordinators to meet consumer needs
- Understanding that MCO readiness is an ongoing process that requires continual monitoring and identification of opportunities to improve processes, and imposing sanctions or rewards when indicated by contract requirements

Based on interviews with officials from the five states, readiness to provide high-quality care coordination and ensure adequate access to providers is a balancing act that must always have consumer needs at the center of the process. States can engage consumers and their advocates in the process by, for example, allowing them to review MCO documents submitted for desk review. Involving consumers in this activity adds another perspective that could strengthen the development of consumer-centered programs. For the same reason, states should also involve consumers and their representatives in onsite review of care coordination role playing and training activities.

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Endnotes

[1] National Council on Aging, *What Are Long-Term Services and Supports*. Accessed at http://www.ncoa.org/public-policy-action/long-term-services--supports/.

[2] D. Scully et al., *In Brief: At the Crossroads: Providing Long-Term Services and Supports at a Time of High Demand and Fiscal Constraint* (Washington, DC: AARP Public Policy Institute, July 2013).

[3] For a more complete explanation of how LTSS are typically financed, see W. Fox-Grage and D. Redfoot, *Medicaid: A Program of Last Resort for People Who Need Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, May 2013).

[4] Some states may also include a few Medicaid-financed primary and acute care services that wrap around the Medicare benefit.

[5] The other two reports are: (a) D. Lipson et al., *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, July 2012). Accessed 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; and (b) P. Saucier, B. Burwell, and A. Halperin, *Consumer Choices and Continuity of Care in Managed Long-Term Services and Supports: Emerging Practices and Lessons* (Washington, DC: AARP Public Policy Institute, August 2013). Accessed at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/consumer-choices-report-full-AARP-ppi-ltc.pdf.

[6] This report (a) defines care coordination; (b) defines provider network adequacy; (c) defines readiness review; (d) summarizes (in Table 1) perspectives from state officials on why readiness to provide care coordination and having an adequate LTSS provider network are critical components of a managed LTSS program; (e) presents (in Table 2) an overview of the characteristics of each state's managed LTSS program; and (f) discusses themes derived from interviews with state officials. Summaries of interviews with officials from each state (e.g., case studies), including their advice to states that are new to managed LTSS or trying to decide whether to move to a managed LTSS delivery system, are available online.

[7] A long-standing barrier to coordinating care for Medicare-Medicaid enrollees has been the financial misalignment between Medicare and Medicaid. To begin to address this issue, CMS has established the Financial Alignment Demonstration Project that will allow CMS and states to test two models to better align Medicare and Medicaid financing and integrate primary, acute, behavioral health, and long-term services and supports for their Medicare-Medicaid enrollees. One of these models is the capitated model under which a state, CMS, and an MCO enter into a three-way contract and the MCO receives a prospective blended payment to provide comprehensive, coordinated care. CMS has developed readiness review criteria for the Financial Alignment Demonstration, which are summarized at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMP_ReadinessReview_Presentation.pdf.

[8] An engaged family caregiver is a relative, neighbor, or friend who assumes an important role in the person- and family-centered care plan as directed by the consumer.

[9] Although regulatory language (42 C.F.R. 438.207) requires MCOs to provide documentation to the state to establish provider network adequacy, all of the interview states went beyond this requirement by going on site to MCO offices to evaluate whether their IT systems could support network adequacy.

[10] States that do not have enough staff to devote to oversight should consider contracting out such services. For a fuller discussion of this issue, see Lipson et al., *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports*.

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

[12] Consumer direction is an orientation to the delivery of HCBS whereby informed consumers make choices about the services they receive. Individuals have the primary authority to make choices that work best for them, regardless of the nature or extent of their disability or the source of payment for services.

[13] The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) requires states to implement Medicaid Estate Recovery Programs. Under certain circumstances, the law requires states to pursue recovering costs for medical assistance consisting of the following: (a) nursing home or other long-term institutional services; (b) HCBS; (c) hospital and prescription drug services provided while the person was receiving nursing facility or HCBS; and (d) at a state's option, any other items covered by the Medicaid State Plan.

[14] In a Medicaid FFS delivery system, providers are paid for each service they provide (like an office visit, test, or procedure). Medicaid.gov, *Fee-for-Service Delivery System*. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Fee-for-Service.html.

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601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
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