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ASPE RESEARCH BRIEF

HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY

DID THEY OR DIDN'T THEY: A BRIEF REVIEW OF SERVICE DELIVERY VERIFICATION IN MLTSS

Why is Verification Necessary?

There has been a marked increase in states' use of managed care as a tool for delivering long-term services and supports (LTSS) to vulnerable populations. In the past eight years, the number of states using Medicaid managed LTSS (MLTSS) has grown from eight to 16 with another ten states projected to bring MLTSS on-line by 2014.[1] Because of this trend, it is important to think about the ways in which states are verifying that members served by a managed care organization (MCO) actually receive the services they need. This is essential in the context of participant protections and quality.

Verifying the delivery of services is a critical component of oversight due to the vulnerability of populations served in MLTSS. Establishing a process for confirming that program participants receive their authorized services assures the protection of their health and welfare. In addition, there is potential for creating a link to monitoring back-up plans -- whether they were implemented and substitute service providers are deployed when the primary worker does not show up. Back-up plans are important ways to reduce the risk of a critical event due to a lack of services.

The Centers for Medicare and Medicaid Services (CMS) regulations require that managed care entities be responsible for assuring access to and monitoring delivery of service. In fact, the regulations specify that managed care entities and their providers meet standards for "timely access to care and services." The managed care entities are also expected to ensure compliance of providers and take corrective action as necessary.[2]

States are using a variety of Medicaid authorities to offer MLTSS, often tied to the quality expectations outlined in the 1915(c) home and community-based services (HCBS) waiver. Within the waiver application and technical guide, the requirement is that "services are delivered in accordance with the service plan, including in the type, scope, amount, duration and frequency."[3]

This Brief addresses how states and MCOs verify that providers deliver the LTSS that are specified in members' service plans and that are authorized by the MCOs. We found similarities among the states, but unique approaches as well.

Whose Responsibility Is It Anyway?

The crux of the task is determining if the member actually got the services he/she was supposed to. Conceptually, the monitoring processes used in MLTSS are not all that different from monitoring service receipt in a fee-for-service environment. States' methods range from a basic comparison of service authorizations against provider claims to detailed reports on provider attendance generated from electronic provider logs.

However, it is important to consider the additional layer of monitoring that is part of MLTSS. Since states typically delegate first line monitoring to the MCO, including monitoring of service receipt, the MCO's oversight activities are an important part of the quality enterprise. Some states are prescriptive in how they wish MCOs to verify service receipt and other states leave it to the MCO's discretion. The MCO, because it is accountable to the state for overseeing providers, is a key player in ascertaining whether members receive services. It is first and foremost the MCO's responsibility to know if there has been a breakdown in service delivery and to have a mechanism for addressing gaps when they occur.

The state, in turn, has a responsibility to insure that the MCO has adequately monitored the providers and verified service receipt. Both the state and the MCO are accountable to the persons served by the MLTSS programs, to taxpayers and ultimately to the Federal Government because these services are funded by Medicaid (and depending on the program, could be funded by Medicare as well).

Monitoring Approaches

The methodologies that states use of service verification fall into three categories:

1. A comparison of paid claims against services authorized.

2. A review of the case record to compare services delivered to services authorized in the care plan.

3. Electronic provider attendance logs.

Many states engage in retrospective monitoring by comparing some indication that the service specified in the service plan was received. The indicator that the service was received could be a notation in a member's case record or a provider claim (or encounter data). While a couple of states verify service receipt against reimbursement, this is not a particularly recommended approach because it omits the critical comparison between the service plan and service receipt. This comparison may be more appropriate as an indicator of fiscal accountability.

The methodologies used by Tennessee and Arizona are instructive. Both go beyond a simple record review or claims comparison. Arizona requires the MCOs to report gaps when services are not provided as authorized. The MCO must submit this information to the state monthly and include the reason for the gap in services as well as what actions were taken to address the missed service.

An electronically sophisticated approach is employed in Tennessee using the Electronic Visit Verification (EVV) system. The system records the days and times the member wishes a service to be delivered. When the direct care worker arrives, s/he calls the EVV system from the member's home to "clock-in" and then "clocks-out" in the same manner when the visit is complete. If, within 15 minutes of a scheduled visit, the worker does not call in, an alert goes to the provider agency, the MCO and the state. From there, the provider and MCO determine whether a back-up worker must be summoned. EVV also has the capacity to generate reports on late and missed visits. The MCO and the state use these reports to monitor service receipt -- not only that the service was delivered, but also whether it was delivered timely.

Reporting Frequency
State MLTSS programs vary in the frequency of mandated MCO reports on service receipt. Some states require monthly reporting, others quarterly and yet others annually. In Tennessee, given the EVV system, reports can be generated at any interval by either the MCO or the state.

Back-Up Supports
There are a variety of reasons it is important to determine if MLTSS participants are receiving needed services. Because lack of services for these populations can sometimes result in serious incidents, several states have a clearly defined expectation for back-up provisions when unplanned gaps in services occur.

For example, Michigan's MLTSS program (which serves persons with mental illness, substance use disorder and intellectual disabilities/developmental disabilities) requires MCOs to provide emergency and after-hours access to services for persons experiencing a mental health emergency. Contract language in Wisconsin, Arizona and Pennsylvania specifies that MCOs must provide back-up supports 24-hours per day, seven days per week. Pennsylvania has a similar requirement, but it is specific to back-up for those services that are medically necessary. Because Tennessee uses real-time information on service gaps, MCOs are required to respond proactively when the EVV system signals a worker no-show.

States' Considerations

There are obviously choices when it comes to designing (or re-designing) a method to verify service delivery in MLTSS programs. When considering options, there are some specific things states may want to consider.

First is the method by which service delivery will be verified -- whether it be through verification of claims, record reviews or real-time validation strategies. If a retrospective

approach for MCO reporting is used, the state should consider pairing it with a telephone number the member can call if they experience a service gap. The person at the other end of the line should be able to summon a back-up provider to meet the member's need.

An alternative approach is an electronic verification system which not only offers access to reports for any time interval, but also provides the additional security when paired with provider and MCO staff monitoring in real-time for service gap alerts. This approach has not yet been broadly adopted and involves an up-front cost to install, as well as costs associated with staffing resources to monitor the EVV system for no-shows. For this approach to be most effective, it needs to be monitored (by providers and the MCO) in real-time so that when an alert is sent indicating a worker no-show, either the provider or MCO can proactively contact the member to assess the immediate need, and then deploy a back-up worker as necessary.

The EVV system approach may also pose some challenges for verifying self-directed services. One of the features of self-direction is that it allows members to have flexibility for when a service is delivered. As currently configured, EVV is driven by the date/time the worker is scheduled to arrive. If a member asks the worker to come at a different time without formally requesting a change in the system, then a worker no-show alert is erroneously triggered. Moving forward it will be instructive to follow how Tennessee addresses this seeming constraint in the EVV system.

Who decided how service delivery will be verified is also a consideration. States can either be prescriptive about how they want the MCO to verify service receipt, or they can leave it to the discretion of the MCO. One thing to keep in mind is that contract language outlining the strategy for how MCOs shall verify services will insure some modicum of consistency among MCOs. That, in turn, allows the state to make more valid comparisons across MCOs and for the program statewide.

Finally, if the state decides upon a retrospective reporting approach, it will also want to think about the frequency of MCO reports. The more frequently the intervals at which MCOs are required to report, the quicker the state can intervene if a problem becomes evident.

Summary

It is clear from this review of service delivery verification in MLTSS that states rely on a variety of approaches. What is important is not necessarily the method by which MCOs and states confirm service delivery, but rather simply knowing "did they" or "didn't they" receive the necessary services and supports, as well as being organized to take timely action when service gaps do occur, thus safeguarding member health and well-being.

Endnotes

1. Saucier, P., J. Kasten, B. Burwell and L. Gold. 2012. *The Growth of Managed Long Term Services and Supports (MLTSS) Programs: A 2012 Update*. CMS. Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf. Accessed August 8, 2013.

2. CMS, Code of Federal Regulations, 42 CFR §438.206.c.1.i-vi.

3. Medicaid 1915(c) HCBS waiver quality requirements for service delivery are specified in Appendix D of Version 3.5 of the waiver application. Available at http://157.199.113.99/WMS/faces/portal.jsp. Accessed August 30, 2013.

In this Brief, the authors Teja Stokes, Beth Jackson and Pat Rivard from Truven Health Analytics, describe the three main methods used to determine whether or to what extent MLTSS enrollees receive the services authorized as necessary for them in their care plans.

This Brief was prepared under contract #HHSP23337003T between the U.S. Department of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy (DALTCP) and Truven Health Analytics, Inc. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/office_specific/daltcp.cfm or contact the ASPE Project Officer, Pamela Doty, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Pamela.Doty@hhs.gov

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Did They or Didn't They?: A Brief Review of Service Delivery Verification in MLTSS

HTML	http://aspe.hhs.gov/daltcp/reports/2013/verifyRB.shtml
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