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MEDICAID 1115 DEMONSTRATIONS

Critical Incidents, Grievances, and Appeals: Data to Support Monitoring and Evaluation of Medicaid Managed Long Term Services and Supports (MLTSS) Programs

Jenna Libersky, Alena Tourtellotte, Margaret Coit, and Debra Lipson

Introduction

When managed care enrollees and providers report adverse experiences with their care, it gives Medicaid officials important information about the performance and quality of the program. Adverse experience reports—which take the form of critical incidents, appeals, and grievances—are often cited by state Medicaid officials as the most important tool they have in overseeing managed long term services and supports (MLTSS). Reports of critical incidents, grievances, and appeals can be "the canary in the coal mine," alerting the state to system-wide issues much faster than findings from retrospective evaluations. These reports also offer a window into the problems enrollees experience with access to services, network adequacy, and—for home and community-based services (HCBS) in particular—the assessment and care planning process under MLTSS. Compared with evaluations of program quality, member complaints allow program managers to intervene with concrete solutions in real time. For example, it is easier to respond to member reports about specific transportation providers who do not show up on time than to act on annual survey results indicating that a given proportion of members sometimes could not get transportation when they needed it (Libersky et al. 2016).

However, MLTSS program administrators and stakeholders who try to use reports of critical incidents, grievances, and appeals to systematically evaluate access and quality across MLTSS programs face significant limitations. Federal requirements—and sometimes state requirements—offer an overarching definition of critical incidents, appeals, and grievances but may not specify how state and plans should categorize the reasons the reports are filed, resulting in data that are difficult to standardize and analyze across programs. While all states are required to collect and use data on appeals and grievances to monitor MLTSS programs [42 CFR 438.66(b)-(c)], the Centers for Medicare and Medicaid Services (CMS) does not require all states to report this information to the agency; where it is required, the type of information, level of detail, and frequency of reporting vary by program, authority type, and point in time (Government Accountability Office [GAO] 2017).

THE MEDICAID CONTEXT

Medicaid is a health insurance program that serves people with limited household incomes, including children, adults, individuals with disabilities, and seniors. Medicaid is administered by states and is jointly funded by states and the federal government. Within a framework established by federal statutes, regulations, and guidance, states can choose how to design aspects of their Medicaid programs, such as benefit packages and provider reimbursement. Although federal guidelines may impose some uniformity across states, federal law also specifically authorizes experimentation by state Medicaid programs through section 1115 of the Social Security Act. Under section 1115 provisions, states may apply for federal permission to implement and test new approaches to administering Medicaid programs that depart from existing federal rules yet are consistent with the overall goals of the program and budget-neutral to the federal government.

For the past two decades, states have increasingly turned to private managed care plans to deliver long-term services and supports (LTSS) to Medicaid beneficiaries with disabilities who need assistance with activities of daily living. Section 1115 is one of several federal authorities that states can use to operate managed long-term services and supports (MLTSS) programs. In contrast to fee-for-service, which pays providers for each service they deliver, states that operate MLTSS programs pay managed care plans a fixed per-member-per-month (PMPM) amount to provide all covered services for enrollees. The capitated PMPM payment arrangement—combined with contract requirements to protect enrollees—can create an incentive for the plans to improve care coordination, reduce unnecessary services, and increase the availability of less expensive home- and community-based services as an alternative to institutional care.

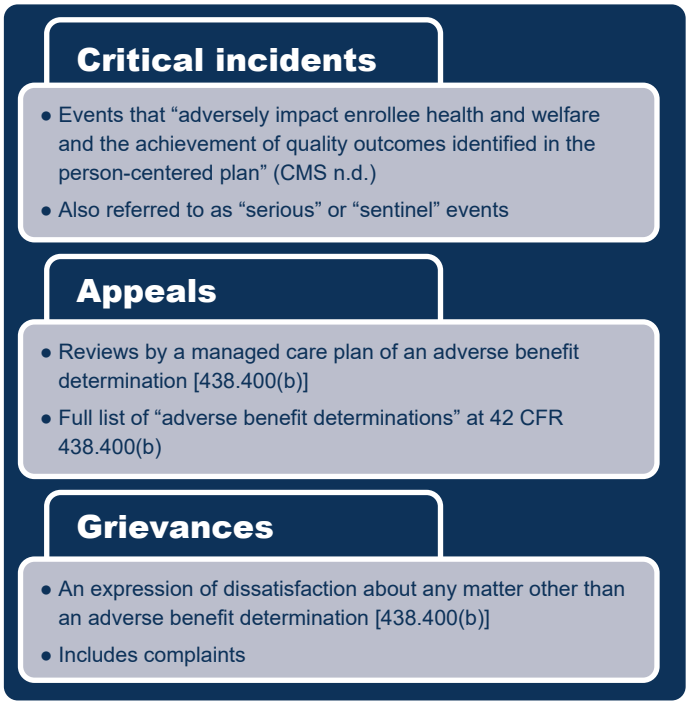
This brief summarizes trends in critical incidents, grievances, and appeals data available to CMS in five states that operate MLTSS programs under section 1115(a) authority: Kansas, New Mexico, New York, Rhode Island, and Tennessee.[1] The brief starts by defining critical incidents, grievances, and appeals, then discusses federal and state requirements for collecting, using, and reporting the information. Next, it presents cross-state and state-specific data reported in CMS's Performance Metrics Database and Analytics (PMDA) system, which compiles information from 1115(a) demonstration monitoring reports. The brief concludes by discussing data limitations, implications for the national evaluation of MLTSS programs, and a proposed typology that would facilitate cross-state comparisons of adverse events.

Background on Critical Incidents, Appeals, and Grievances

Critical incidents

Definition. Although there is no single definition of a critical incident, CMS uses the term to refer to events that "adversely impact enrollee health and welfare and the achievement of quality outcomes identified in the person-centered plan" (CMS n.d.; Figure 1). A 2013 Office of the Assistant Secretary for Planning and Evaluation (ASPE) report further defined critical incidents as "events or occurrences that cause harm to members or serve as indicators of risk to a member's health or welfare" (Rivard, Jackson, and Stokes 2013). Such events, which states may also call "serious" or "sentinel" events, typically include instances of abuse, neglect, and exploitation. Depending on the state, they may also include things like 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 (Rivard, Jackson, and Stokes 2013).

Figure 1. Definitions of critical incidents, appeals, and grievances



Use in oversight of MLTSS. CMS expects states to have systems in place to identify, report, and investigate critical incidents, but many states that operate MLTSS delegate much of this responsibility to managed care plans (CMS 2013; Rivard, Jackson, and Stokes 2013). States may require managed care plans to receive critical incident reports from providers and investigate or review reports to protect members' health and welfare. Some states establish critical incident procedures that managed care plans must follow, while others allow the plans to develop their own approaches (Rivard, Jackson, and Stokes 2013).

CMS also expects states to use their critical incident systems to monitor and track trends so they can identify ways to improve their systems (CMS 2013), but the degree to which states are involved in identifying and resolving systemic problems varies. Of the five MLTSS plan contracts reviewed for this report (Kansas, New Mexico, New York, Rhode Island, and Tennessee), contracts from two states (Tennessee and New Mexico) require plans to analyze trends and identify opportunities for improvement to reduce the occurrence of incidents.

Managed care plan reporting to states. Although CMS expects states to use information on critical incidents to improve the delivery of MLTSS, states have the ability to determine how often and in what format managed care plans have to report critical incidents, and these requirements are reported in the plan's contract or other policy and procedural documents. Requirements usually include (1) types of incidents that the managed care 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 managed care organization (MCO), 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.

In terms of the types of incidents being reported, a 2013 review of MLTSS contract language for critical incidents in Arizona,

Michigan, Minnesota, North Carolina, Pennsylvania, Tennessee, Texas, and Wisconsin found that all eight states had protocols for reporting and addressing instances of abuse, neglect, and exploitation. Some states specified additional incidents that must be reported, whereas others allowed the managed care plan to specify additional types of incidents it will report. Some states also required the plan to contact the state within a certain timeline for serious incidents like death, abuse, neglect, and exploitation, which allowed the state to ensure such incidents are properly investigated and mitigated. Other states required plans to measure the time involved in handling critical incidents as part of their overall approach to monitoring and assuring quality (Rivard, Jackson, and Stokes 2013).

Appeals and grievances

Definition of appeals. As described in Figure 1, federal rules give all Medicaid managed care enrollees the right to file an appeal in response to an "adverse benefit determination," which could include actions like a managed care plan's decision to reduce, terminate, or deny previously authorized services or to deny payment for a service [42 CFR 438.400(b)]. For example, a beneficiary 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 a beneficiary is authorized to receive (GAO 2017).

Federal requirements at 42 CFR Subpart F outline the general process and timeline for appeals but leave the details and some flexibilities to the discretion of states. Generally, after the enrollee files an appeal with the managed care plan, the plan will review the appeal through an internal process and either approve it (that is, overturn its original decision and resolve the appeal in favor of the enrollee), or deny it (that is, uphold the plan's original decision). If a plan denies the appeal, the enrollee can request that the state review the plan's decision through the state's fair hearing process, in which state officials rule on whether the managed care plan's decision should be upheld (GAO 2017). Enrollees must exhaust the managed care plan's appeal process before proceeding to a state fair hearing; however, states have the option to offer enrollees an external review concurrent with the managed care plan appeal (438.402(c)(1)(i); 438.408(f)(1)(ii); CMS n.d.).

Definition of grievances. An enrollee can file a grievance with a managed care plan to express dissatisfaction with any matter that cannot be appealed [42 CFR 438.400(b); Figure 1]. 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 beneficiary's grievance, the managed care plan or state conducts an independent review and determines what, if any, steps are needed to resolve the grievance (GAO 2017). As with appeals, federal requirements at 42 CFR Subpart F outline the general process and timeline for grievances but leave the details to the discretion of states and managed care plans.

To complement the formal grievance and appeal system, some states sponsor hotlines to register complaints from consumers and providers on matters that are not subject to grievance and appeals (Lipson et al. 2012).[2] The process for submitting complaints and the way the information is used also varies by state. Florida, for example, has an extensive complaint reporting system, which provides a rich source of data for MLTSS administrators (see Exhibit 1).

Managed care plan reporting to states. Similar to critical incidents, federal regulations require managed care plans to keep records about grievances and appeals but allow states to determine the details. 42 CFR 438.416(b) requires managed care

Exhibit 1. Using complaints to monitor MLTSS in Florida

During its transition to statewide managed long term care in 2013, Florida's Agency for Health Care Administration (AHCA) created a hub to compile complaints from a variety of sources, including those submitted through the state website, 1-800 number, managed care plans, Aging and Disability Resource Centers, and the ombudsman. AHCA monitors the hub continuously to address individual issues and to identify systemic issues across plans or providers. Complaints were coded as high, medium, or low priority and triaged according to topic. The required response times depended on the level of the complaint; urgent issues required attention within 24 hours. State agency officials report that the hub has allowed them to identify and address any systemic issues quickly, and for this reason, it is still in use today.

Florida also uses its complaint hub to validate plan-reported information and inform process improvements related to grievances and appeals, missed services, denials, reductions, terminations, and fraud and abuse. For example, AHCA compares reports of missed services to complaints received on the hub. AHCA also uses the information from the complaint hub to inform weekly calls with plan contract managers to talk through any issues related to beneficiaries or systems (Lester and Libersky 2014). As part of its recent transition of long-term care to comprehensive plans, Florida is revising the structure of the data in the complaint hub and hopes to use it for trend data to be published to its public-facing dashboard.

plans to collect and retain information on general descriptions of the reason for each grievance or appeal; the date received; date of each review, including review meetings; resolution at each level of appeal or grievance; date of resolution at each level; and the name of the covered person for whom the appeal or grievance was filed. Within these bounds, states may require managed care plans to report aggregate counts of grievances filed in the reporting period (as required in New York and Rhode Island), or information on grievances reported in a prior period by resolution status (New Mexico). Although states like Rhode Island require 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.

Availability of and variation in data reported to CMS

Depending on the federal authority under which their MLTSS programs operate, states must report different types of information on adverse events to CMS. States that operate MLTSS programs under 1115(a) demonstration authority are often required to include critical incidents, appeals, and grievances in their quarterly and annual monitoring reports to CMS. Details on how to measure these indicators are specified in the demonstration's special terms and conditions and customized for each state (GAO 2017). States that operate MLTSS using managed care authority concurrent with section 1915(c) waiver programs or 1915(i) state plan benefit options are required to report critical incidents in line with the minimum requirements for those programs.

Within states that use 1115(a) demonstration authority to operate MLTSS, there is significant variation in what CMS collects through the quarterly and annual monitoring reports that populate PMDA (Table 1). A 2017 GAO report of six MLTSS programs operated under 1115(a), 1915(a)/(c), or 1915(b)/(c) authority also found variation in state reporting on the following dimensions: whether MLTSS data is reported at all; whether it is reported separately from that of other programs; the level of detail used to describe the process of appeals and grievances, which can include complaints and problems reported by consumers; the topical description used to categorize appeals or grievances; and the numerical format for reported grievances. In some cases, GAO found CMS did not require states to report

Table 1. Adverse experience information reported in PMDA in five study states

Data type	Kansas (KanCare)	New Mexico (Centennial Care)	New York (MLTC)	New York (MAP)	Rhode Island (Rhody Health Options)[a]	Tennessee (CHOICES)
Critical incidents						
Summary counts	X	X	X	X		
By reason filed		X				
By service type		X				
By status or outcome	X					
By managed care plan		X				
By collecting entity[b]						
Appeals and state fair hearings						
Summary counts	X	X	X	X		X
By reason filed	X		X			X
By service type	X					
By status or outcome	X	X	X			X
By managed care plan						
By collecting entity[b]	X	X	X			X
Grievances						
Summary counts	X	X	X	X		
By reason filed	X		X			
By service type	X	X	X			
By status or outcome	X		X			
By managed care plan						
By collecting entity[b]	X	X	X			

Source: Availability is based on an abstraction of PMDA data taken March 2019 and covering 2011–2018.

[a] The PMDA data extract used for this report did not contain any data on critical incidents, appeals, or grievances for Rhody Health Options.

[b] Collecting entities include ombudsmen, Aging and Disability Resource Centers, state agencies, and others.

MAP = Medicaid Advantage Plus; MLTC = Managed Long-Term Care; PMDA = Performance Metrics Database and Analytics

data to the agency even when it was available. For example, even though rates of appeals or grievances were available in four of the study states, CMS did not require any of the states to report them (GAO 2017).

Findings

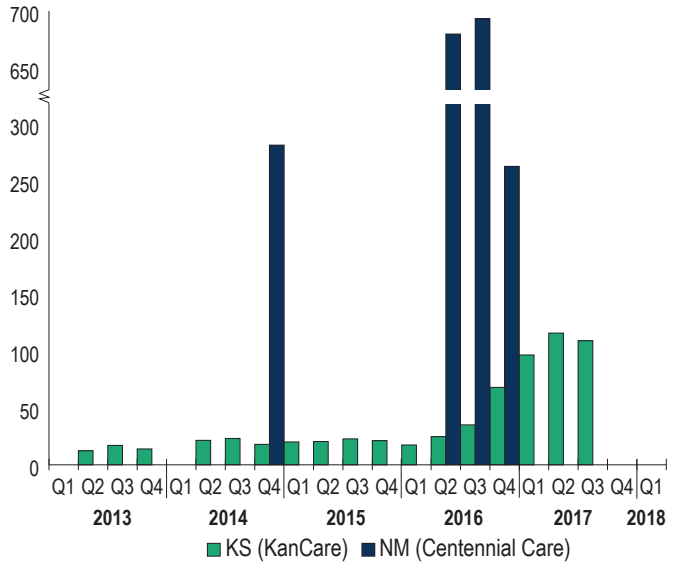
This section presents data on counts of critical incidents, appeals, and grievances for five study states that operate MLTSS programs under section 1115(a) demonstration authority: Kansas, New Mexico, New York, Rhode Island, and Tennessee. At the time of this report, these five states were under consideration for being included in CMS's national final evaluation of MLTSS programs (Wysocki et al. 2019). The data were derived from the PMDA database, which contains structured information from the quarterly and annual monitoring reports that states submit to CMS on their section 1115(a) demonstrations. Because the detailed information in PMDA varies significantly across states (as shown in Appendix A), this section presents summary counts of adverse events in each state per 1,000 MLTSS enrollees (see Methods and Data Sources, at the end of this text, for details). It also provides more detailed information for one of the five states—Tennessee—that was not reported to CMS via PMDA.

Cross-state findings from PMDA

Critical incidents. Of the five study states, the PMDA database only contained information on critical incidents in three, and the quality and richness of each state's data varied significantly. As shown in Figure 2 and Appendix Table A.1, from 2013 to 2015 Kansas reported consistently low rates of critical incidents per 1,000 MLTSS enrollees (around 20 per 1,000 enrollees) with a surge for the last quarter of 2016 through 2017 (between 60 and 120 per 1,000 enrollees). This trend corresponds with KanCare's waiver renewal denial in January 2017 and could either reflect issues that raised concerns with regulators or enhanced reporting requirements imposed on the state to ensure compliance. Notably, New Mexico reported much higher rates than Kansas for specific quarters in 2014 and 2016, with no reported critical incidents for other quarters. Compared to both Kansas and New Mexico, New York's Managed Long-term Care (MLTC, not shown) program reported negligible rates of critical incidents per 1,000 MLTSS enrollees (ranging from less than 0.01 to 3) across most quarters during the five-year span, whereas New York's other program, Medicaid Advantage Plus (MAP, not shown), reported similarly low rates (ranging from less than 0.01 to 6) but only during 2017 and 2018.

Grievances. Although Kansas was the only state to report grievances during 2013 (rates ranged from .05 to .09 per 1,000 enrollees), several states reported consecutive quarters of data from 2014 to 2018, as shown in Figure 3 below and in Appendix

Figure 2. Critical incidents per 1,000 enrollees, 2013–2018



Source: 1115(a) quarterly and annual monitoring reports recorded in the PMDA database, enrollment data collected for the design of the national Managed Long-Term Services and Supports (MLTSS) final evaluation (Wysocki et al. 2019), and CMS's 2017 Medicaid Managed Care Enrollment Reports.

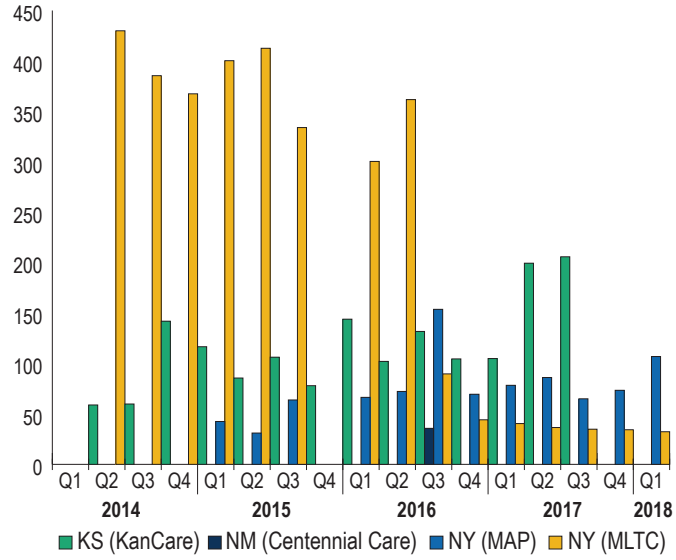
Notes: Our analysis of PMDA data for Kansas found many critical incidents of unknown status and category, indicating 14,281 total critical incidents filed. However, Kansas's Annual Report to CMS Regarding Operation of 1115(a) Waiver Demonstration reported no critical incidents of unknown status and category, with a total of 6,947 critical incidents reported. The source of this discrepancy is not known.

Rates of critical incidents in both of New York's programs are under 10 per 1,000 MLTSS enrollees and therefore are not shown in Figure 2. Between 2013 and 2018, the rates of critical incidents ranged from 0 to 6 per 1,000 enrollees and 0 to 3 per 1,000 enrollees for MAP and MLTC, respectively.

Table A.2. Kansas and New York's MAP program rates per 1,000 MLTSS enrollees rose between the first and last time period of data reported (increasing from 59 in Q2 of 2014 to 206 in Q3 of 2017 for Kansas, and from 43 in Q1 of 2015 to 107 in Q1 of 2018 for New York's MAP program), although trends varied from quarter to quarter. From 2014–2016, New York's MLTC program rates were higher than those in other states but dropped to rates lower than most states after Q2 of 2016. The dramatic change suggests variation in reporting requirements rather than real trends in the number of grievances reported. New Mexico reported scant data on grievances across all years, reporting counts only for Q2 of 2014 and Q3 of 2016.

Appeals. Across the four states that reported data in PMDA, only rates of appeals per 1,000 MLTSS enrollees in New York's MLTC program resemble those shown for grievances, while other states show different patterns (Figure 4). The MLTC program had higher rates of appeals in 2014 and 2015, followed by a dramatic drop in rates of appeals from Q3 2016 onward. In contrast, New York's MAP program reported the highest rates of appeals of all programs in Q1 and Q2 of 2016, although trends before and after this time period revealed lower rates. Kansas reported consistently lower rates of appeals per 1,000 MLTSS

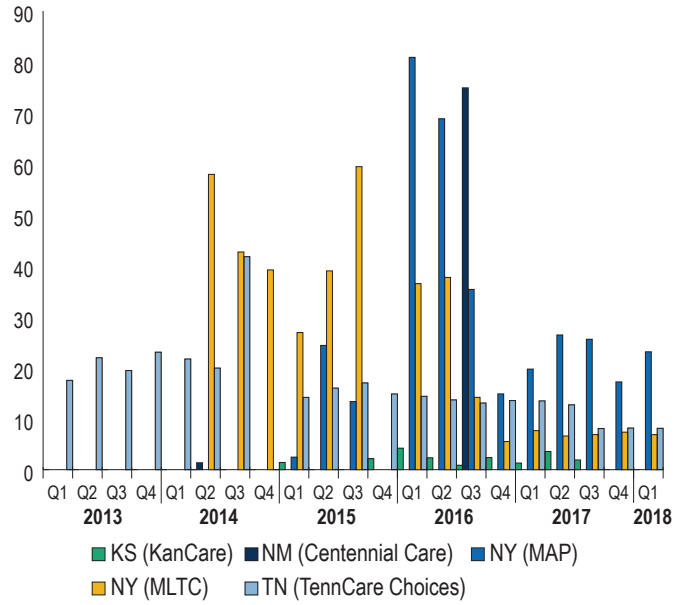
Figure 3. Grievances per 1,000 enrollees, 2014–2018



Source: 1115(a) quarterly and annual monitoring reports recorded in Performance Metrics Data and Analytics (PMDA), enrollment data collected for the design of the national MLTSS final evaluation (Wysocki et al. 2019), and CMS's 2017 Medicaid Managed Care Enrollment Reports.

Notes: New York's quarterly monitoring reports from 2013 include counts of grievances for the MLTC program, but for unknown reasons, these counts are not included in PMDA. For the following quarters and programs, rates of grievances are under 10 per 1,000 MLTSS enrollees and therefore are not shown in Figure 3: 2013 for Kansas's KanCare program; Q1 2014 for New York's MLTC program; and Q2 2014 for New Mexico's Centennial Care program.

Figure 4. Appeals per 1,000 enrollees, 2013–2018



Source: 1115(a) quarterly and annual monitoring reports recorded in Performance Metrics Data and Analytics (PMDA), enrollment data collected for design of the national MLTSS final evaluation (Wysocki et al. 2019), and CMS's 2017 Medicaid Managed Care Enrollment Reports.

Notes: According to PMDA data for Tennessee, 2,625 appeals were filed in 2013, 3,408 in 2014, and 1,884 in 2015. However, in data prepared for GAO, the state reported far fewer appeals (245 in 2013, 136 in 2014, and 54 in 2015; Killingsworth 2016). For Q3 2015, the rate of appeals for Kansas's KanCare program is under 1 per 1,000 MLTSS enrollees and therefore is not shown in Figure 4.

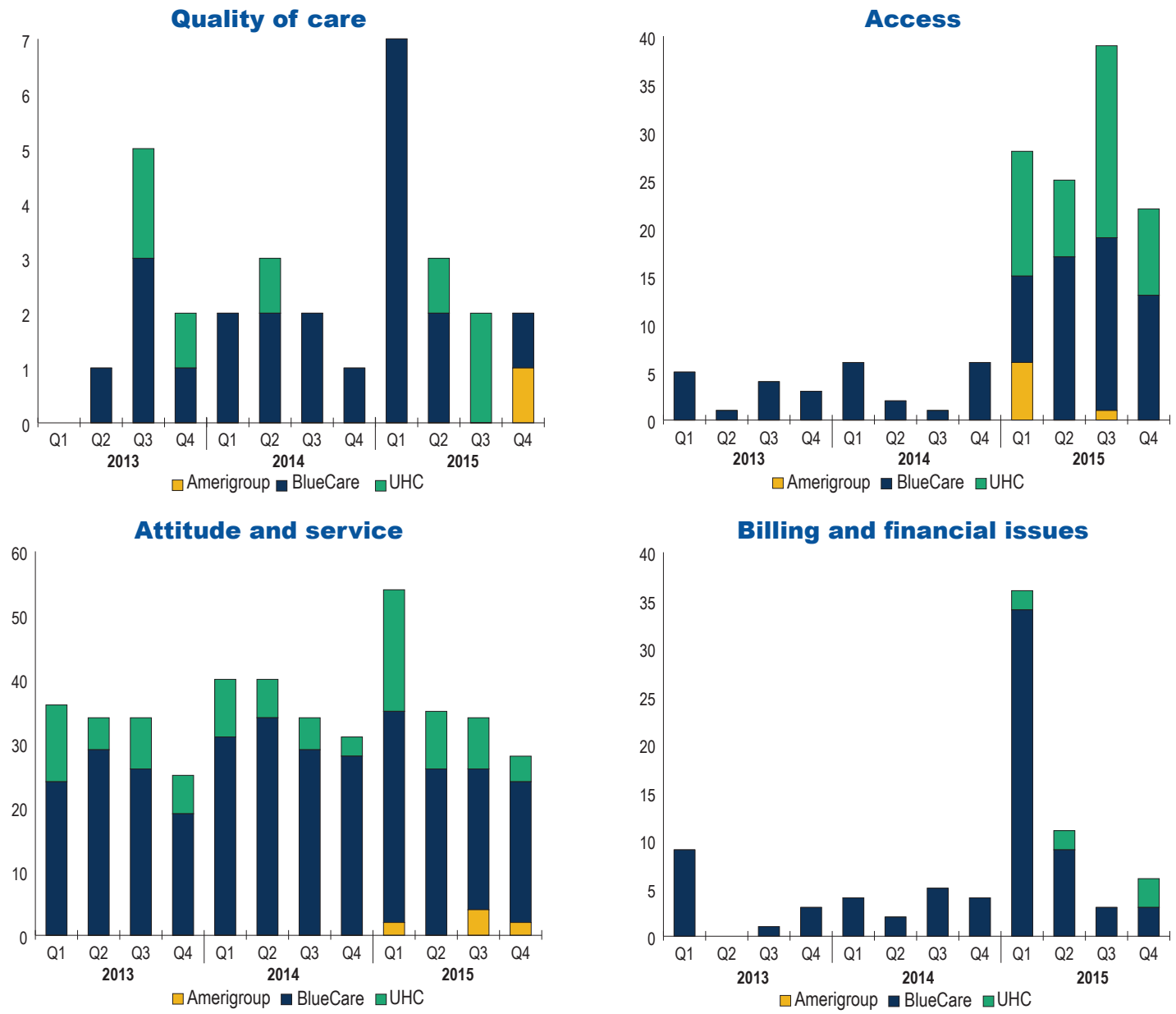
enrollees (ranging from less than 0.01 to 4). In Tennessee, with the exception of Q3 2014 through Q1 2015, trends in appeals per 1,000 MLTSS enrollees were less volatile than those seen in other states (between 8 and 23). New Mexico again reported data in only two quarters (Q2 of 2014 and Q3 of 2016), one of which showed high rates of appeals (75 per 1,000 enrollees).

State-specific data not reported to CMS via PMDA: Tennessee example

Grievances. Although variation in the level of detail that each state reports in PMDA makes it difficult to analyze cross-state findings by category, some topics are reported in rich detail by certain states (Appendix Tables A.1–A.4). However, it is often the case that states collect and retain data from managed care plans that have much more detail than what they report to CMS. For example, though PMDA did not contain data on grievances in Tennessee's CHOICES program, data obtained directly from Tennessee provide plan-level counts of grievances according to the categories that the National Committee for Quality Assurance requires as part of its accreditation process (Figure 5). Though the plan-level counts suggest some plans perform better than others, each plan had different criteria for what qualified as a grievance, suggesting to state staff who use these data that members were no more dissatisfied with BlueCare than they were with the other plans (Killingsworth 2016). It is also important to note that beginning in January 2015, all three managed care plans began operating in all regions of the state, and the reassignment of members increased the overall count of grievances, with the rate falling during the latter half of 2015. The enrollment counts that would be needed to standardize the grievances relative to enrollment were not available for this brief.

Appeals. PMDA contains quarterly data on the reason appeals are filed and their outcomes, but Tennessee also collects and uses monthly, plan-level appeals by service category. Rates of appeals per 1,000 enrollees across all managed care plans are presented by category in Figure 6 and by outcome in Figure 7. The state uses these data to track and analyze trends in appeals over time by plan and service area, allowing for in-depth follow-up with plans as necessary (Killingsworth 2016). For example, as a result of one plan's high rate of appeals, TennCare placed a temporary moratorium on the plan's reductions or terminations of certain LTSS benefits in early 2013. The agency also implemented a review process with the plan before taking any adverse actions; the process included a review of assessments and care plans to ensure appropriate actions (Killingsworth 2016).

Figure 5. Count of grievances by category and plan among Tennessee CHOICES enrollees, 2013–2015



Source: Killingsworth 2016.

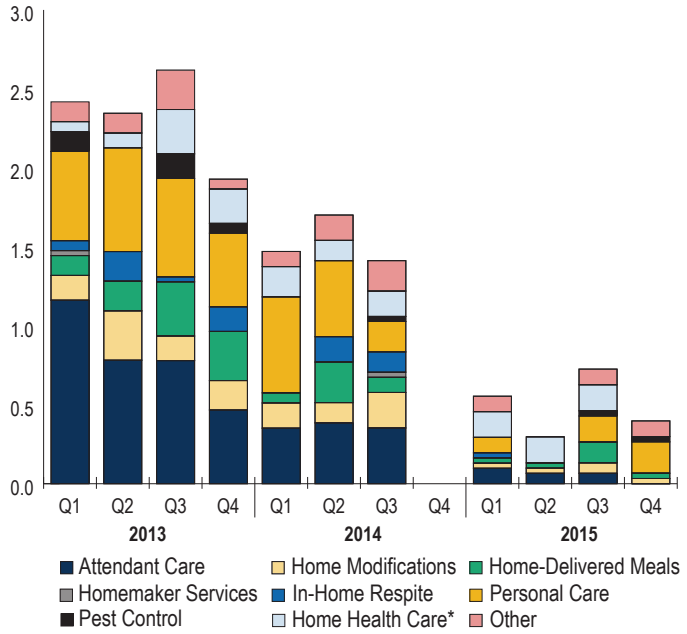
Note: Grievances in "other" category not reported. No grievances in the category of "quality of practitioner office site" were reported. Grievances are presented as counts, because MLTSS enrollment by plan was not available for this brief to support rate calculations.

Discussion and Limitations

Comparing rates of critical incidents, appeals, and grievances across states highlights the wide variation in the volume, frequency, and topical detail available to CMS through the PMDA database. Some of this variation is due to differences in CMS's requirements for state reporting for MLTSS programs operating under section 1115(a) demonstration authority, as GAO explained in its 2017 study.[3] This brief highlights that data availability and detail can also vary over time. One state interviewed for this brief suggested that because CMS collects the data to monitor program implementation, CMS may require more frequent and more granular reporting in the early stages of a new or expanding demonstration. If CMS administrators detect no serious issues with a program's performance, they might loosen the requirements so that states report less data, less often. Were CMS to view rates of critical incidents, appeals, and grievances as key outcomes to be studied in MLTSS evaluations, it might require states to report such data consistently over the course of the entire demonstration period.

The variation observed in the data also reflects state flexibility to determine how health plans must track and report adverse events, or state-specific circumstances that shape the way states collect information and resolve issues. For example,

Figure 6. Appeals per 1,000 enrollees by service type among Tennessee CHOICES enrollees, 2013–2015



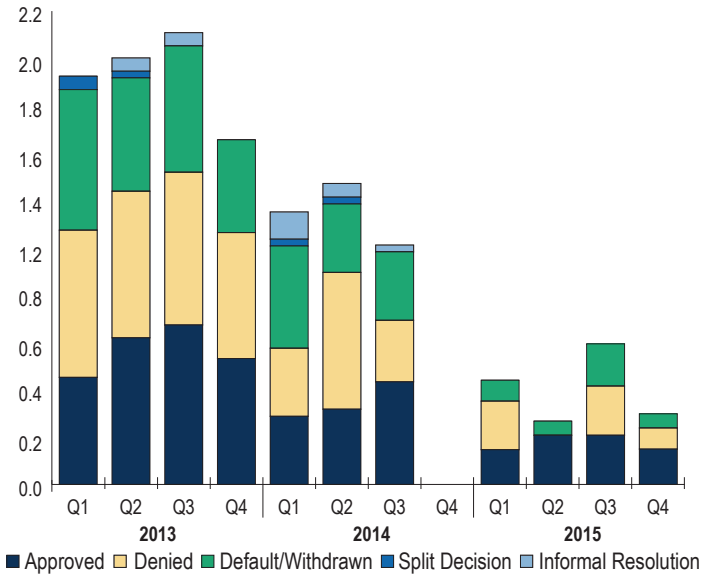
Source: Killingsworth 2016 and CMS's 2017 Medicaid Managed Care Enrollment Reports.

Notes: Other includes monthly fee, private duty nursing, companion care, assistive technology, in-patient respite, personal emergency response system – install, adult day care, and consumer directed personal care.

The total number of appeals by service type (519) is greater than the total number of appeals over the three-year period (435) because a single appeal could be associated with more than one service type. Rates for Q4 of 2014 are not presented as MLTSS enrollment counts for that quarter were not available to support rate calculations.

Home Health Care and Private Duty Nursing are provided outside the MLTSS program; however, persons in MLTSS may also receive these benefits. Removal of these services would cause the number of CHOICES-specific appeals to be 451 (2.58% of total appeals). Without the inclusion of Home Health and Private Duty Nursing, over the three-year measurement period the combination of Attendant Care (32%) and Personal Care (29%) account for 61% of the MLTSS appeals. Home Delivered Meals accounts for an additional 12% of the three-year total of MLTSS appeals.

Figure 7. Appeals per 1,000 enrollees by outcome among Tennessee CHOICES enrollees, 2013–2015



Source: Killingsworth 2016 and CMS's 2017 Medicaid Managed Care Enrollment Reports.

Notes: Rates for Q4 of 2014 are not presented because MLTSS enrollment for that quarter was not available.

although most states allow managed care plans to address first-level appeals, Tennessee's Medicaid agency settled a lawsuit in 2003 by agreeing to revise the way it receives and processes all appeals.[4] The consent decree that formalized the settlement prescribed time frames for the resolution of appeals that differ from those set forth under federal regulation (Killingsworth 2016), resulting in data that have different categories of detail than what other states might collect. As another example, in states like Florida that apply a no-wrong-door approach to filing grievances, it's possible that individuals could file similar reports with both the plan and another entity (like the state Medicaid agency or ombudsman office) and the reports would be double-counted.

Organizational characteristics of the managed care plans and beneficiary support system (BSS) entities[5] in each state also affect the volume of reports collected. For example, plans that provide more support to beneficiaries who wish to report a critical incident, or file a grievance or appeal, could have higher counts than plans that allow similar events to go unreported. Likewise, BSS entities that provide more intensive beneficiary support services to managed care enrollees may help resolve issues that would otherwise result in filing an official grievance or appeal. State policies and requirements may also influence the degree of support a plan or BSS entity provides.

Some of the study states are examining critical incidents, grievances, and appeals in state-specific 1115(a) demonstration evaluations; however, none report the data with enough specificity or consistency to support its use in a cross-state evaluation. In designing their evaluations, states are given discretion to identify research questions appropriate to their 1115(a) demonstrations. But if the research questions do not explicitly address critical incidents, grievances, and appeals, evaluators are not required to include the data in the report. For example, New Mexico's research questions do not address grievances and appeals, so while its interim evaluation includes information on the process used to collect them, it does not include counts or measures of grievances and appeals that could inform assessments of performance and outcomes over time (Deloitte 2017).

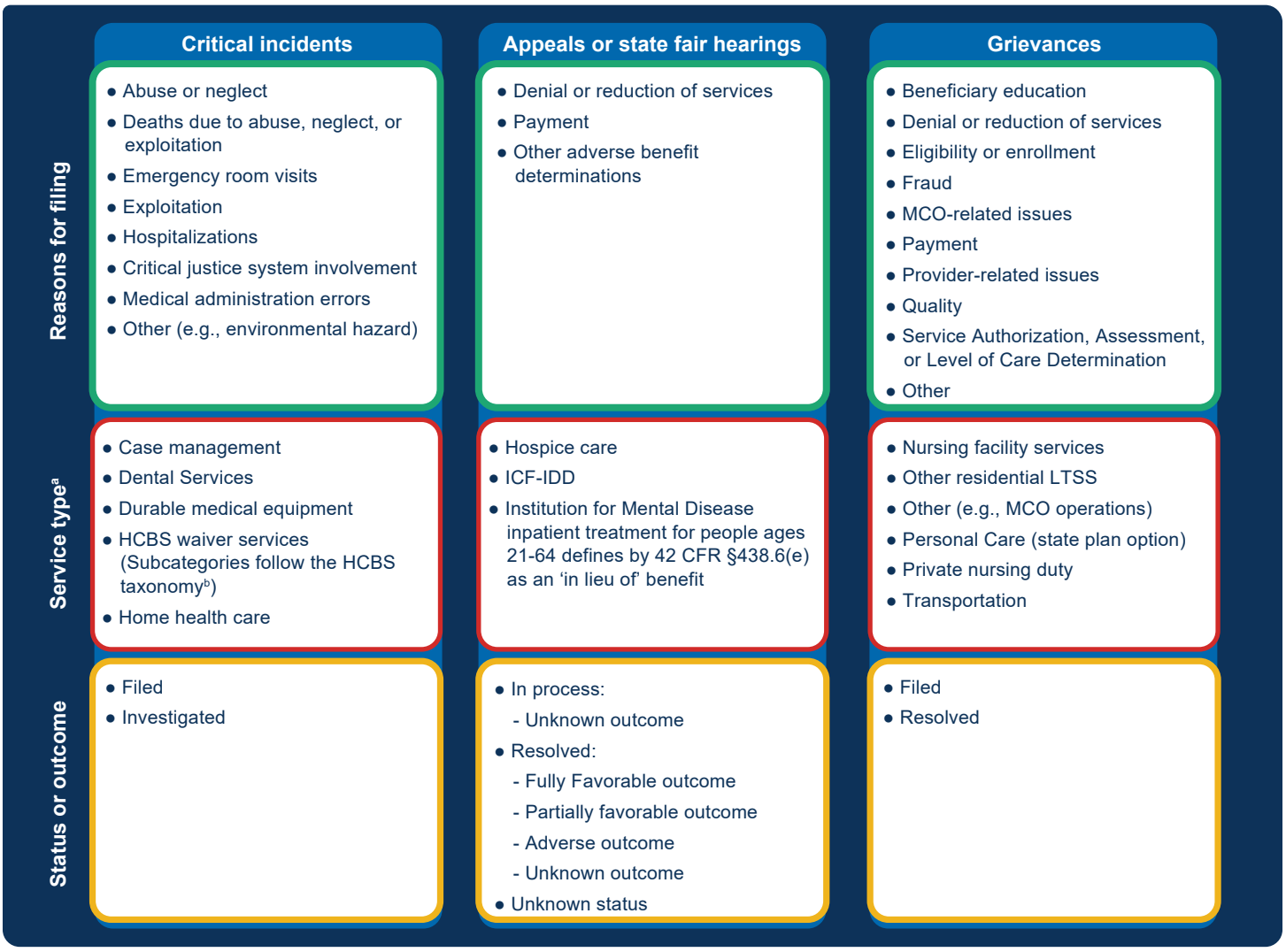
Conclusions and Implications for Evaluations of MLTSS Programs

Because of the wide variation in state reporting, it is difficult to compare the reasons for and the volume and resolution of critical incidents, grievances, and appeals across states and MLTSS programs. Even for counts that have been standardized by the number of enrollees in each state, trends vary significantly across states. It is unclear how much of this variation stems from differences in the incidence of adverse events, what counts as a critical incident in each state, or state and managed care plan systems and processes for adjudicating appeals and grievances.

Evaluators assessing outcomes in individual state MLTSS programs could consider using these data to substantiate program-level trends observed in other data sources or to suggest root causes for observed program trends. For example, the national evaluation of MLTSS programs will use Medicaid administrative data to measure trends in hospital care and LTSS service use, and survey data to measure trends in beneficiary experience and quality of life. If the evaluation finds that service use in a given program is down at the same time the number of appeals concerning adverse benefit determinations is up, it would suggest that managed care plans' denial of payment or authorization for services might be inhibiting access to services. Similarly, if measures of beneficiary experience are poor, and counts of grievances or critical incidents are on the rise, evaluators could investigate whether specific sets of common providers, settings, or other factors contribute to both trends. By using the data in this way, evaluators would be following the example of state Medicaid staff who report that the data are most useful for identifying in-state or in-plan trends that require more investigation.

Cross-state evaluations designed to compare the rate of critical incidents, grievances, and appeals of MLTSS programs will continue to face challenges unless CMS and states develop a common typology for defining, classifying, and measuring these indicators, and apply it consistently. Figure 8 proposes a typology based on the data sources used and consulted for this brief, including CMS's PMDA system for section 1115(a)

Figure 8. Potential typology for the reporting of critical incidents, appeals or state fair hearings, and grievances



[a] Service type categories are adapted from the typology used in CMS's Medicaid Managed Care Enrollment reports and limited to those most relevant to MLTSS users. The Enrollment Reports are available at: https://www.medicaid.gov/medicaid/managed-care/enrollment/index.html

[b] Subcategories for the HCBS taxonomy are described in Peebles and Bohl 2014, available at: https://www.ncbi.nlm.nih.gov/pubmed/25343057

HCBS = home and community-based services; ICF-IDD = intermediate care facilities for individuals with intellectual disabilities; LTSS = long-term services and supports; MCO = managed care organization.

demonstration reporting, Medicaid managed care enrollment reports, and evaluations of Financial Alignment Initiative demonstrations. The typology defines three types of reports: (1) critical incidents, (2) appeals or state fair hearings, and (3) grievances. It also establishes a common set of categories for: (1) the beneficiary's reason for filing the report (that is, the event that occurred or the issue the beneficiary experienced); (2) the service type related to the event or issue; and (3) the status or outcome of the report. This brief applied the typology to categorize existing data that CMS collects from states, as shown in Appendix Tables A.1–A.4. By requiring states to report future quarterly and annual monitoring data according to this typology, CMS can also begin to collect data that is sufficiently consistent across states and time to be used in cross-state evaluations of MLTSS programs.

METHODS AND DATA SOURCES

This brief presents findings from two primary sources of data: (1) an excerpt from CMS's Performance Metrics Database and Analytics (PMDA) system, and (2) tables provided by the state of Tennessee, originally prepared for GAO in August 2016. IBM Watson Health specified and cleaned the excerpt of PMDA data to focus only on measures of critical incidents, grievances, and appeals for MLTSS; the authors of this brief performed additional cleaning to group counts according to categories in the proposed typology. Quarterly MLTSS enrollment used to standardize counts are derived from section 1115(a) quarterly and annual monitoring reports and state-specific enrollment reports, as compiled by IBM Watson Health (Wysocki et al.). Data from Tennessee are presented in their original form, which were compiled to support the 2017 GAO report and sent by P. Killingsworth to the authors of this brief in August 2019. To supplement data from these two sources, the authors searched external quality review reports and 1115(a) evaluations for additional reports of critical incidents, grievances, and appeals. They requested supplementary data from all of the states featured in the brief, but only Tennessee was able to provide the requested data within the timeline. The authors also conducted calls with Medicaid staff in Florida and Rhode Island to provide context for the data and its findings.

ABOUT THE MEDICAID SECTION 1115 EVALUATION

In 2014, the Center for Medicaid and CHIP Services within the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica Policy Research, IBM Watson Health, and the Center for Health Care Strategies to conduct an independent national evaluation of the implementation and outcomes of Medicaid section 1115 demonstrations. The purpose of this cross-state evaluation is to help policymakers at the state and federal levels understand the extent to which innovations further the goals of the Medicaid program and to inform CMS's decisions regarding future Section 1115 demonstration approvals, renewals, and amendments.

The evaluation focuses on four types of demonstrations: (1) delivery system reform incentive payment (DSRIP) programs, (2) premium assistance, (3) beneficiary engagement and premiums, and (4) managed long-term services and supports. This issue brief is one in a series of short reports based on semiannual tracking and analyses of demonstration implementation and progress. These briefs informed an interim evaluation report in 2018 and will inform a final evaluation report in 2020.

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Endnotes

[1] Although Florida operates its managed long-term care program under 1915(b)/(c) authority, it reports calls and complaints on MLTSS to CMS as part of the 1115 demonstration reporting requirements for its Managed Medical Assistance program. Florida provided additional data to inform this issue brief and participated in an interview to provide context on its reporting.

[2] In some states, the term "complaint" is used interchangeably with "grievance;" the PMDA also contains data with each label. For simplicity, this report uses the term "grievance" to refer to either grievances or complaints.

[3] The GAO study identified variation in reporting requirements across six states that operate MLTSS using either 1115(a), 1915(a)/(c), or 1915(b)/(c) authority: Arizona, Delaware, Kansas, Minnesota, Tennessee, and Texas.

[4] In 2003, Tennessee settled Grier v. Goetz by agreeing, among other things, to more carefully consider the appeals of beneficiaries whose claims for treatment were denied coverage under its Medicaid program. For details, see Grier v. Goetz, No. 3:79-cv-03107 (M.D. Tenn. Apr. 23, 2012).

[5] As defined in 42 CFR 438.71, a beneficiary support system (BSS) entity helps LTSS users enrolled in managed care by serving as an access point for complaints or concerns about enrollment and access to covered services, and providing education and assistance on grievances and appeals and the state fair hearing process, among other things. It also helps the state identify, remediate, and resolve systemic issues based on a review of LTSS program data.

Appendix A

Table A.1 Critical incidents, total annual counts by topic and type, 2013–2018[a]

State (Program)		2013	2014	2015	2016	2017	2018
Kansas (KanCare)	**All critical incidents**	1,960	2,879	2,936	5,066	14,281	4,352
	Status or outcome, all	1,960	2,879	2,936	5,066	14,281	4,352
	In process–outcome unknown	936	1,856	1,787	2,482	6,947	2,096
	Unknown	1,024	1,023	1,149	2,584	7,334	2,256
	Reason for filing, all	1,960	2,879	2,936	5,066	14,281	4,352
	Abuse or neglect		0	0	0	3	56
	Unknown	1,960	2,879	2,936	5,066	14,278	4,296
New Mexico (Centennial Care)	**All critical incidents**		22,497	12,601	61,179		
	Status or outcome, all		22,497	12,601	61,179		
	In process–outcome unknown		9,485	5,329	25,677		
	Unknown		13,012	7,272	35,502		
	Reason for filing, all		22,497	12,601	61,179		
	Abuse or neglect		2,028	1,082	5,743		
	Death		1,544	1,127	4,210		
	Environmental hazard		191	106	483		
	Exploitation		544	224	838		
	Other		708	485	1,093		
	Unknown		17,482	9,577	48,812		
	Service type, all		22,497	12,601	61,179		
	Behavioral health		1,372	752	4,355		
	Emergency services		6,398	3,466	18,935		
	HCBS–unspecified		1,048	427	1,510		
	Unknown		13,679	7,956	36,379		
New York (Medicaid Advantage Plus)	**All critical incidents**					114	62
	Status or outcome, all					114	62
	In process–unknown					114	62
New York (Managed Long Term Care)	**All critical incidents**	85	749	659	848	1,679	606
	Status or outcome, all	85	749	659	848	1,679	606
	In process–unknown	85	749	659	848	1,679	606

[a] Data abstracted from the PMDA system were at the quarterly level. Annual totals given in this table are sums of quarterly counts. Empty cells indicate missing quarterly counts.

Table A.2. Grievances, total annual counts by topic and type, 2013–2018[a]

State (Program)		2013	2014	2015	2016	2017	2018
Kansas (KanCare)	**All grievances**	964	9,884	13,379	16,676	20,534	15,755
	Status or outcome, all	964	9,884	13,379	16,676	20,534	15,755
	Adverse outcome	0		0	0	0	25
	Resolved–outcome unknown	957	739	2,340	1,370	1,034	1,370
	Unknown	7	9,145	11,039	15,306	19,500	14,360
	Reason for filing, all	964	9,884	13,379	16,676	20,534	15,755
	Abuse or neglect		0	0	0	0	0
	Access	3	440	395	174	202	100
	Beneficiary education		0	0	9	9	485
	Denial or reduction of services		97	105	49	40	34
	Eligibility or enrollment		657	953	1,797	1,993	1,180
	Fraud		0	0	0	0	6
	MCO-related issues		888	1,244	1,024	850	1,241
	Other		1,558	1,500	3,829	4,708	1,599
	Payment		350	442	362	256	322
	Provider-related Issues		97	76	48	78	61
	Quality	4	45	134	109	222	271
	Service authorization,		2	13	2	0	10
	assessment, or level of care	957	5,750	8,517	9,273	12,176	10,446
	Service type, all	964	9,884	13,379	16,676	20,534	15,755
	Behavioral health			0	0	0	
	Dental services		84	44	45	63	54
	Durable medical equipment		195	114	47	48	16
	HCBS–caregiver support		0	0	0	0	2
	HCBS–community transition						
	Services		10	17	36	5	2
	HCBS–home-based services			21	6		
	HCBS–unspecified		1,330	2,616	1,345	1,845	1,425
	Health homes		0	0	4	2	0
	Inpatient hospital–unspecified			2			
	Medical–unspecified		403	233	141	151	150
	Nursing facility services		32	15	40		
	Other		62	27	24	41	39
	PACE		1	2	0	2	0
	Prescription drugs		165	184	120	94	58
	Transportation		102	339	90	261	628
	Unknown	964	7,500	9,765	14,778	18,022	13,381

(continued)

State (Program)		2013	2014	2015	2016	2017	2018
New Mexico (Centennial Care)	**All grievances**		81		1,078		
	Reason for filing, all		81		1,078		
	Provider		6		0		
	Unknown		75		1,078		
	Service type, all		81		1,078		
	Durable medical equipment		8		0		
	Transportation		21		207		
	Unknown		52		871		
New York (Medicaid Advantage Plus)	**All grievances**			842	2,212	2,439	1,049
New York (Managed Long Term Care)[b]	**All grievances**		146,037	148,132	121,716	27,094	6,552
	Status or outcome, all		146,037	148,132	121,716	27,094	6,552
	Adverse outcome		20				
	In process–outcome unknown			146	466		
	Resolved–outcome unknown		44,728	42,061	27,478		
	Unknown		101,289	105,925	93,772	27,094	6,552
	Reason for filing, all		146,037	148,132	121,716	27,094	6,552
	Access		690				
	Eligibility or enrollment		120				
	Fraud		129	278	504		
	MCO-related issues		264				
	Other		1,856				
	Payment		52				
	Provider-related Issues		408				
	Unknown		142,518	147,854	121,212	27,094	6,552
	Service Type, all		146,037	148,132	121,716	27,094	6,552
	HCBS–case management		1,144				
	HCBS–day services		86	2	6	2	0
	HCBS–equipment, technology, and modifications		1	2	0	2	0
	HCBS–home-based services		10,606	71	76	87	47
	MCO operations		1,140				
	Other		2,246				
	Other residential LTSS		3	5	8	3	3
	Transportation		30,600				
	Unknown		100,211	148,052	121,626	27,000	6,502

[a] Data abstracted from the PMDA system were at the quarterly level. Annual totals given in this table are sums of quarterly counts. Empty cells indicate missing quarterly counts.

[b] New York's quarterly monitoring reports from 2013 include counts of grievances for the MLTC program, but for unknown reasons, these counts are not included in PMDA.

Table A.3. Appeals, total annual counts by topic and type, 2013–2018[a]

State (Program)		2013	2014	2015	2016	2017	2018
Kansas (KanCare)	**All appeals**			130	338	332	6,842
	Status or outcome, all[b]			130	338	332	6,482
	Reason for filing, all			130	338	332	6,842
	Provider					96	6,678
	Service authorization, assessment, or level of care determination				155	200	102
	Unknown			130	183	36	62
	Service type, all			130	338	332	6,842
	HCBS–Home-based services			27	49	40	62
	HCBS–Unspecified			103	134	0	192
	Unknown				155	292	6,588
New Mexico (Centennial Care)	**All appeals**		301		2,262		
	Status or outcome, all[b]		301		2,262		
New York (Medicaid Advantage Plus)	**All appeals**			247	1,178	719	227
New York (Managed Long Term Care)	**All appeals**		17,216	16,261	14,387	5,298	1,391
	Status or outcome, all[b]		17,216	16.261	14,387	5,298	1,391
	Reason for filing, all		17,216	16,261	14,387	5,298	1,391
	Denial or reduction of services		6,018				
	MCO-related issues		0				
	Other		8				
	Payment		2,526				
	Unknown		8,664	16,261	14,387	5,298	1,391
TN (TennCare CHOICES)	**All appeals**	2,625	3,408	1,884	1,632	1,233	935
	Status or outcome, all[b]	2,625	3,408	1,884	1,632	1,233	935
	Reason for filing, all	2,625	3,408	1,884	1,632	1,233	935
	Denial or reduction of services	1,623	1,189				
	Eligibility or enrollment	56	55				
	Unknown	946	2,164	1,884	1,632	1,233	935

[a] Data abstracted from the PMDA system were at the quarterly level. Annual totals given in this table are sums of quarterly counts. Empty cells indicate missing quarterly counts.
[b] Counts of appeals by outcome are presented in Table A.4.

Table A.4. Appeals by outcome, total annual counts by topic and type, 2013–2018[a]

State (Program)		2013	2014	2015	2016	2017	2018
Kansas (KanCare)	**Appeals to the MCO, all**			130	338	332	6,842
	Favorable to enrollee, all			9	27	75	2,427
	Fully favorable outcome			9	27	75	2,427
	Unfavorable to enrollee, all			16	66	72	984
	Adverse outcome			16	66	72	984
	Unknown, all			105	245	185	3,431
	Resolved–outcome unknown			2	96	185	191
	Unknown			103	149		3,240
New Mexico (Centennial Care)	**Appeals to the MCO, all**		301		2,262		
	Favorable to enrollee, all				388		
	Fully favorable outcome				374		
	Partially favorable outcome				14		
	Unfavorable to enrollee, all				731		
	Adverse outcome				731		
	Unknown, all		301		1,143		
	Unknown		301		1,143		
New York (Medicaid Advantage Plus)	**Appeals to the MCO, all**			247	1,178	719	227
	Unknown, all			247	1,178	719	227
	Unknown			247	1,178	719	227
New York (Managed Long Term Care)	**Appeals to the MCO, all**			16,261	14,387	5,298	1,391
	Favorable to enrollee, all			1,173	994		
	Fully favorable outcome			943	393		
	Partially favorable outcome			230	601		
	Unfavorable to enrollee, all			958	1,416		
	Adverse outcome			958	1,416		
	Unknown, all		17,216	14,130	11,977	5,298	1,391
	Resolved–outcome unknown			706	1,288		
	In process–outcome unknown		820	224	329		
	Unknown		16,396	13,200	10,360	5,298	1,391
TN (TennCare CHOICES)	**Appeals to the MCO, all**	2,625	3,408	1,884	1,632	1,233	935
	Unfavorable to enrollee, all	95	97				
	Adverse outcome	95	97				
	Unknown, all	2,530	3,311	1,884	1,632	1,233	935
	Resolved–outcome unknown	22	413	615	393	300	156
	Unknown	2,508	2,898	1,269	1,239	933	779

[a] Data abstracted from the PMDA system were at the quarterly level. Annual totals given in this table are sums of quarterly counts. Empty cells indicate missing quarterly counts.