MACPAC

HCBS Network Adequacy Standards in MLTSS Programs

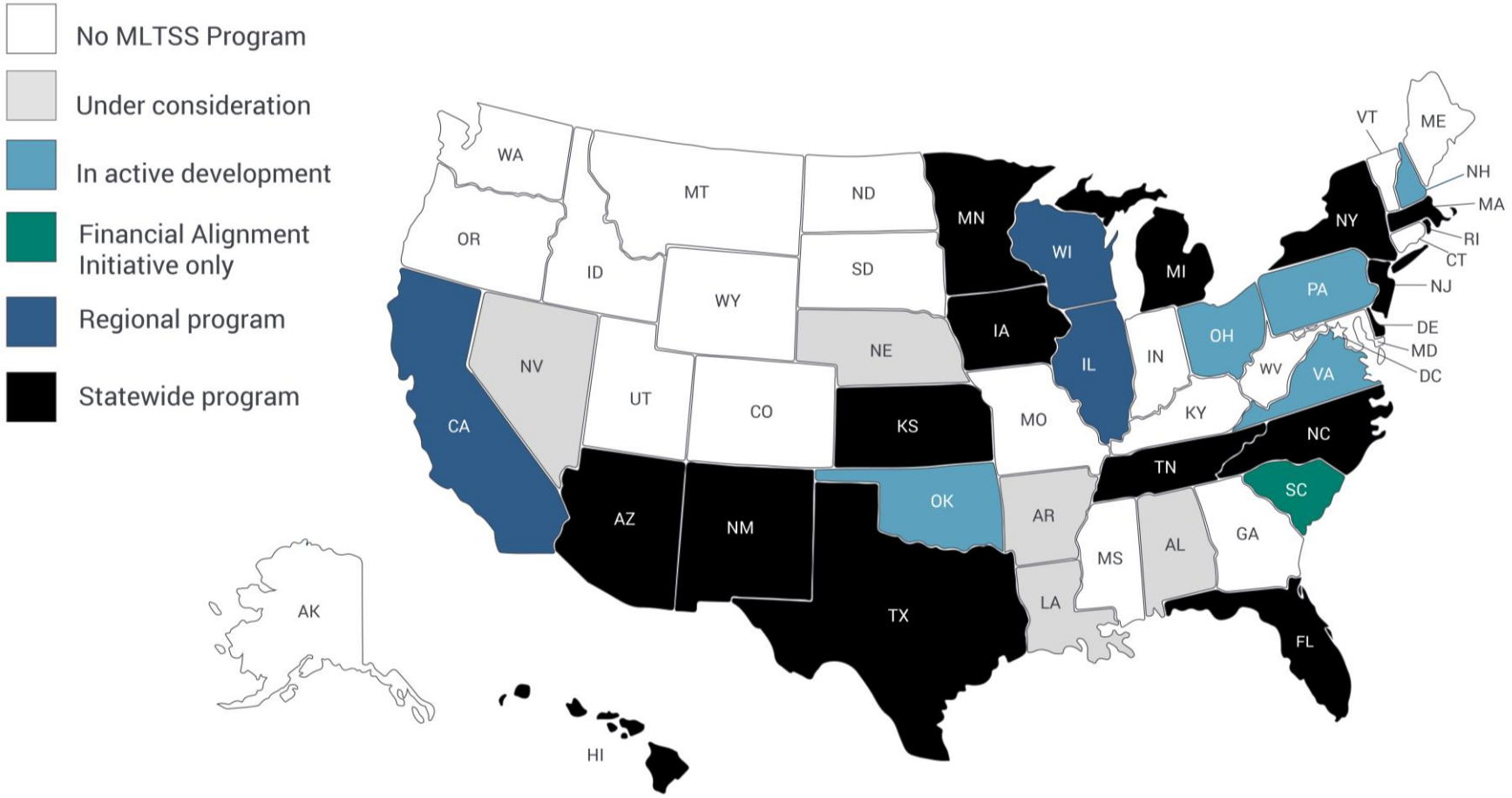
Medicaid and CHIP Payment and Access Commission

Kristal Vardaman

Overview

- Update on managed long-term services and supports (MLTSS) adoption
- Background on home and community-based (HCBS) network adequacy standards and federal requirements
- Results of contract review and interviews with stakeholders
- Conclusions

State MLTSS Adoption



Note: Ohio and Virginia currently operate MLTSS programs through the Financial Alignment Initiative but are developing statewide programs.
Sources: Centers for Medicare & Medicaid Services, National Association of States United for Aging and Disabilities, Ohio Governor's Office of Health Transformation, and Virginia Department of Medical Assistance Services.

HCBS Network Adequacy Standards

Network adequacy standards for HCBS differ from those for acute care

- Traditional standards for services where beneficiaries travel to the provider do not work for HCBS providers that travel to the beneficiary
- HCBS are provided frequently and may be needed for months, years, or decades

HCBS Network Adequacy Standards

- Part of state and federal oversight of MLTSS
- Plans must contract with enough providers to support adequate access to all services in the contract
- Help to determine whether new MLTSS programs or plans are ready to launch
- Monitoring can identify access issues as provider supply and beneficiary needs change over time

Federal Requirements for HCBS Network Adequacy Standards

- Must meet general requirements for Medicaid managed care and specific requirements for MLTSS set by the Centers for Medicare & Medicaid Services (CMS)
- April 2016 Medicaid managed care rule
  - Codified May 2013 guidance
  - Directs states to develop and implement standards, including standards other than time and distance for providers who travel to a beneficiary
  - Did not specify any particular standards states must use
  - Acknowledged the diversity of HCBS among states and lack of consensus on HCBS standards

MACPAC-Funded Research on HCBS Standards

- MACPAC contracted with Health Management Associates to describe existing state HCBS network adequacy standards
- Reviewed 33 contracts in 23 states
- Conducted 12 interviews to understand how standards have evolved
  - Medicaid officials in 4 states (MN, TN, TX, and VA)
  - 2 managed care associations
  - 3 provider organizations
  - 3 beneficiary advocacy organizations

Results of Contract Review

- There were 44 types of contract standards related to HCBS network adequacy
- The most common HCBS network adequacy standards related to time and distance and continuity of care

Results of Contract Review

- Other frequently used standards included requirements that plans:
  - monitor gaps in service;
  - contract with any willing provider;
  - provide procedures for single case agreements;
  - contract with a minimum number of providers; and
  - pay fee-for-service rates.

Results of Contract Review

- Fourteen contracts required plans to monitor gaps in service
  - Required tracking and often reporting of instances when a beneficiary was authorized to receive a service, but the service was not provided on one or more dates on time or at all
  - States and plans may use electronic visit verification systems to support this activity
  - States often require contingency plans

Results of Contract Review

- Three states required that plans submit annual network adequacy plans that describe their existing provider network, how they monitor the timeliness of care, and how they will address deficiencies
- A few contracts had special considerations for rural areas
- States used most standards for all HCBS provider types, and some standards tailored to specific HCBS providers (e.g., personal care services)

Interview Themes

- Stakeholders identified goals for HCBS network adequacy
  - Ensuring beneficiaries have opportunities for self-direction and meaningful choice of providers
  - Contracting with providers with cultural competency in beneficiaries' cultural, linguistic, cognitive, and disability-related needs
  - Measuring outcomes and quality of life
  - Promoting high quality care
- Stakeholders identified provider capacity as a limiting factor in HCBS network development

Interview Themes

- Broad support for using gaps in service reports to evaluate network adequacy on an ongoing basis
- States emphasized that they have moved toward network adequacy standards that reflect whether beneficiaries are getting the care they need, and have been authorized to receive
- Requiring a minimum number of each provider type may be easy to enforce and needed from a readiness perspective, but is insufficient for ongoing monitoring

Conclusions

- Stakeholders did not feel that compliance with the rule's provisions on HCBS network adequacy would be a challenge
- There does not appear to be an impetus for federal action at this time
  - CMS has acknowledged that states are currently in the best position to create standards that address their unique circumstances

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