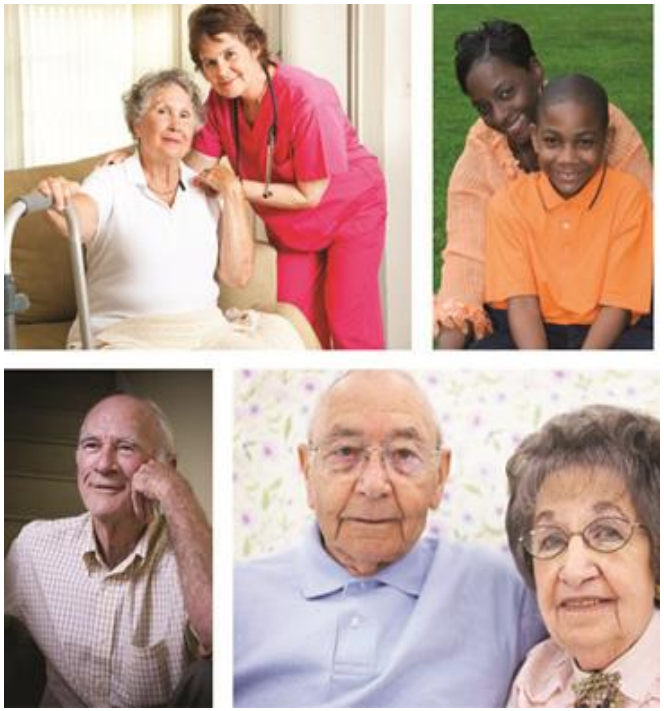


CCC PLUS: DETERMINING NETWORK ADEQUACY

Karen E. Kimsey
Deputy Director of Complex Care
August 29, 2017

Network Adequacy Agenda

- Network adequacy objective
- Network adequacy considerations and methodology
- Network adequacy results
- Network adequacy monitoring and oversight

Network Adequacy Objectives

- To evaluate Member access to care
- To ensure that such access is adequate based upon drive time and distance (versus as the crow flies)
- To encourage provider participation
- To comply with the Federal Managed Care and CCC Plus contract requirements

Network Adequacy - Stakeholder Input

- Began Stakeholder "speed-dating" sessions (over 100 meetings since February 2017)
  - Encouraged provider participation
    - Contracting/credentialing, & relationship building
    - Streamlining administrative and payment processes
- Received Stakeholder input on Contract standards, including for network adequacy in April of 2017
- Presented network standards and methodology to the CCC Plus Advisory Committee in June 2017

Network Adequacy Methodology Timeline

- Task force formed in fall of 2016
- Developed health plan network submission manual
- Began receiving provider network submissions in Dec of 2016
- Piloted analysis approach with several provider files in submitted monthly in the spring of 2017
- Revised submission requirements to include final contract network requirements (i.e., including stakeholder input)
- Finalized network adequacy 'scorecard' and exception request/approval process in May of 2017
- Network adequacy is assessed and monitored monthly

Network Adequacy DMAS Internal Work Flow

Receive monthly whole network submissions

Conduct data quality and value set validation and provide data quality feedback to submitting health plans

Clean files are feed into our SmartData SAS analytical engine and output files are feed into Tableau to generate maps and scorecards

Results presented to agency management for decision making and shared with submitting health plans

Exception process and ongoing network monitoring

Network Adequacy Considerations

Do the members have access to the services they need?

- Who will be in managed care?
- Where do they live?

Member Health and Demographic Info

- How do we identify each type of provider?
- Which providers can deliver which services?

Available Providers

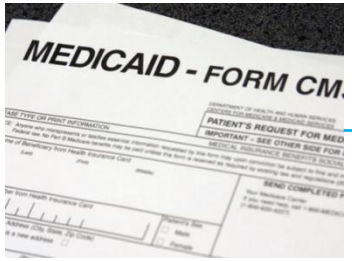
Actual Driving Distance

- What is the driving distance/time between the member and the provider?
- How many members have reasonable access to providers?

Network Adequacy Methodology

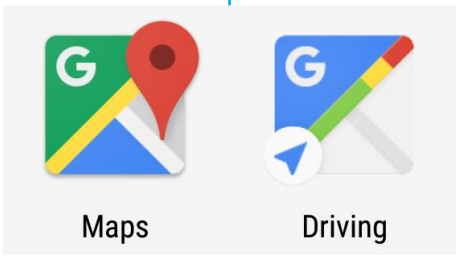
Data Sources Needed to Answer Each Question

Provider Access
Quantify Member Access to Needed Providers



Eligibility Data
Member Addresses

Provider Network Data
Providers Eligible for Specific Service Delivery

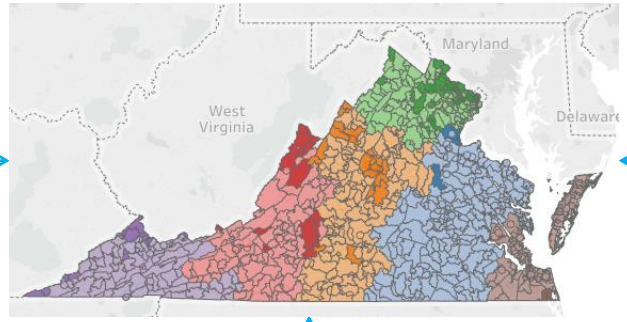


Driving Distance Calculations
External Service

Network Adequacy Methodology

Tools and People Needed to Bring It All Together

Analytics Platform
Processing Capacity

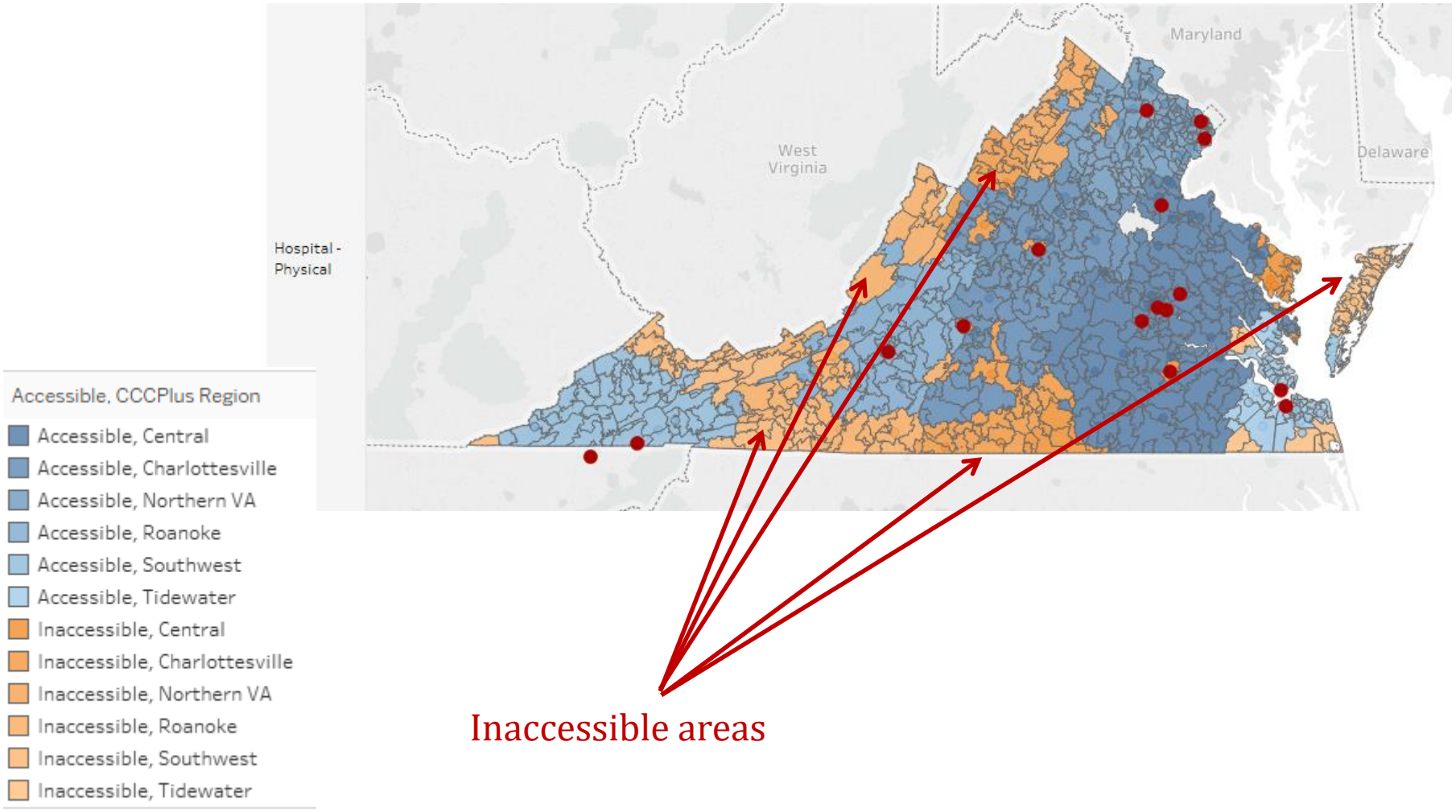


Analytics and CC Plus Program Staff Partnership
Serving Agency Needs

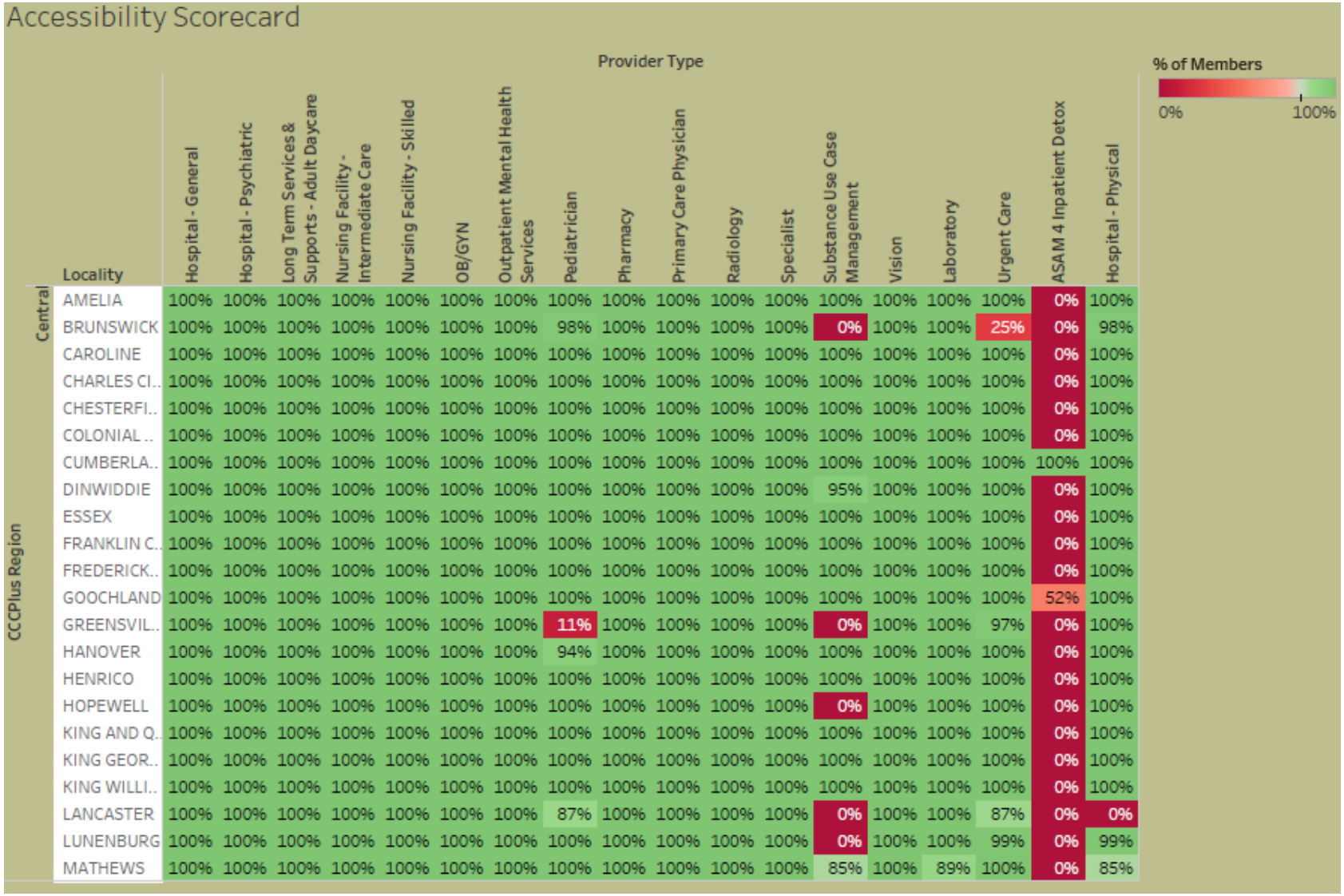
Business Intelligence
Power of Visualization

Visualized Provider Access

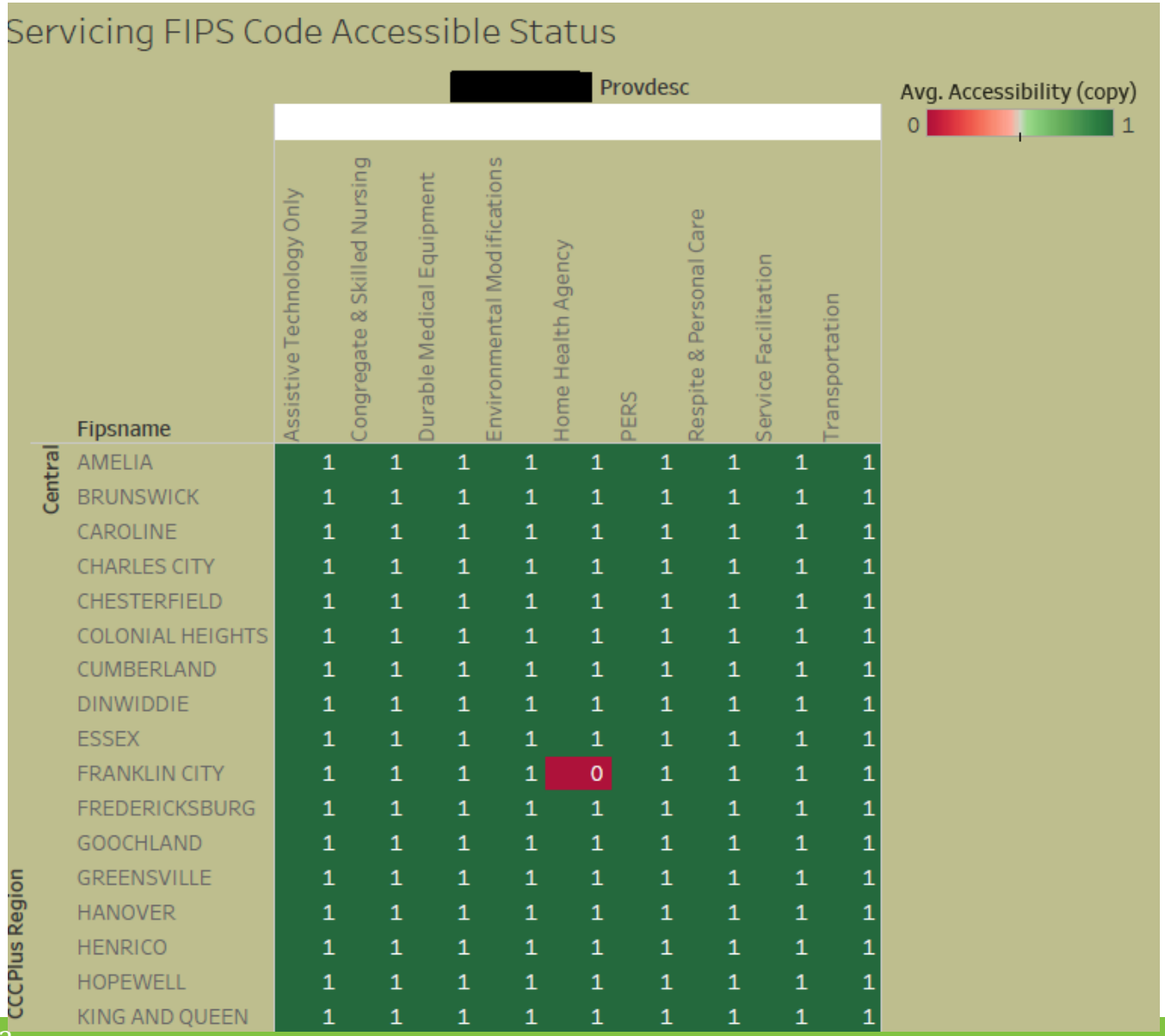
Example of Network Adequacy Map



Example of Network Adequacy Scorecard- Time and Distance



Example of Network Adequacy Scorecard- Choice



Dimensions of Network Adequacy

Provider Travels to the Member

Provider Types that Travel to the Member (e.g. LTSS)	
Provider Type	**# of Providers Required by Locality**
Personal Care and Respite	2
Skilled Nursing	2
Assistive Technology	1
Environmental Modifications	1
Services Facilitation	2
Home Health	2
Personal Emergency Response	1
Assistive Technology	1
Durable Medical Equipment	1

Choice of providers who will travel to the member, by locality; based upon the providers designated service area. Does not include consumer directed providers.

Dimensions of Network Adequacy

Choice – Member Travels to Provider

Requires at Least One Provider	Requires Choice of at Least Two Providers
Adult Day Care	Primary Care Provider & Pediatrician
Psychiatric Hospital	OBGYN
General Hospital	Outpatient Mental Health (Traditional Services)
	Nursing Facility (Skilled & Intermediate)
	Pharmacy

- ✓ *80% of Members within each zip code in the locality must have choice of at least two primary care providers within time and distance standards.*
- ✓ *75% of Members within each zip code in the locality must have choice of at least two OBGYN, mental health, nursing facility, and pharmacy providers within time and distance standards.*

Dimensions of Network Adequacy
Drive Time and Distance

Provider Types with Time and Distance Standards *Member travels to the provider*		
Standard	**Driving Distance**	**Driving Time**
Primary Care Physician (Urban)	15 miles	30 minutes
Other provider types (Urban)	30 miles	45 minutes
Primary Care Physician (Rural)	30 miles	45 minutes
Other provider types (Rural)	60 miles	75 minutes

- ✓ *80% of Members within each zip code in the locality must have access to primary care within time and distance standards.*
- ✓ *75% of Members within each zip code in the locality must have access to care for other than primary care services within time and distance standards.*

Dimensions of Network Adequacy
Timeliness Standards

In addition to network time/distance and choice of provider standards, the Contract specifies minimum standards for timely access to services:

- Emergency Services - immediately
- Urgent Care – as expeditiously as the member's condition requires and within no more than 24 hours
- Routine Primary Care – as expeditiously as the member's condition requires and within no more than 30 days of the members request
- LTSS – within no more than 5 business days of the screening

Dimensions of Network Adequacy
Out of Network

The health plan must provide out-of-network coverage in all of the following circumstances

- Continuity of care period - within the first 90 days of enrollment when the provider has an existing relationship with the member;
- When the member resides in a nursing facility that does not participate with the MCO;
- At anytime the type of provider needed is not available in the MCO's network within the time and distance standards;
- Emergency and family planning services

Network Adequacy Results

- Provides a scorecard for each health plan regarding the percent of members by locality who have access within the contract standards
- Provides pass/fail for each locality for critical provider types
- Identifies provider shortage areas
- Used to identify areas for targeted recruitment efforts
- Used to determine health plans eligible to receive member assignments by locality
- Share the results as feedback with the health plans
- Data quality impacts results and needs to be monitored

Monitoring and Oversight

- Monitor network adequacy monthly prior to implementation and at least quarterly post implementation
- Refine network adequacy standards, methodology, and requirements as program matures, considering:
  - provider shortage areas, population demographics, regional differences, exception requests, etc.
- Monitor timely access to care
  - review complaints & appeals; conduct member satisfaction surveys, perform chart reviews, compare date authorized and start of care date on the claim, etc.

HCBS Network Adequacy- A Health Plan Perspective

NASUAD Fall Conference

Baltimore, MD

8/29/2017

Centene Overview

CENTENE® Corporation

WHO WE ARE

St. Louis

based company founded in Wisconsin in 1984

31,500 employees

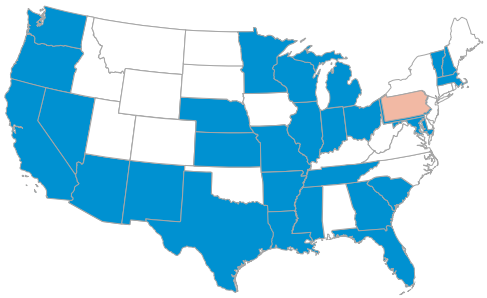
#66 on the Fortune 500 list

#4 Fortune's Fastest Growing Companies (2015)

$40.6B revenue for 2016

$46.4-47.2B expected revenue for 2017

WHAT WE DO



With government sponsored healthcare programs:

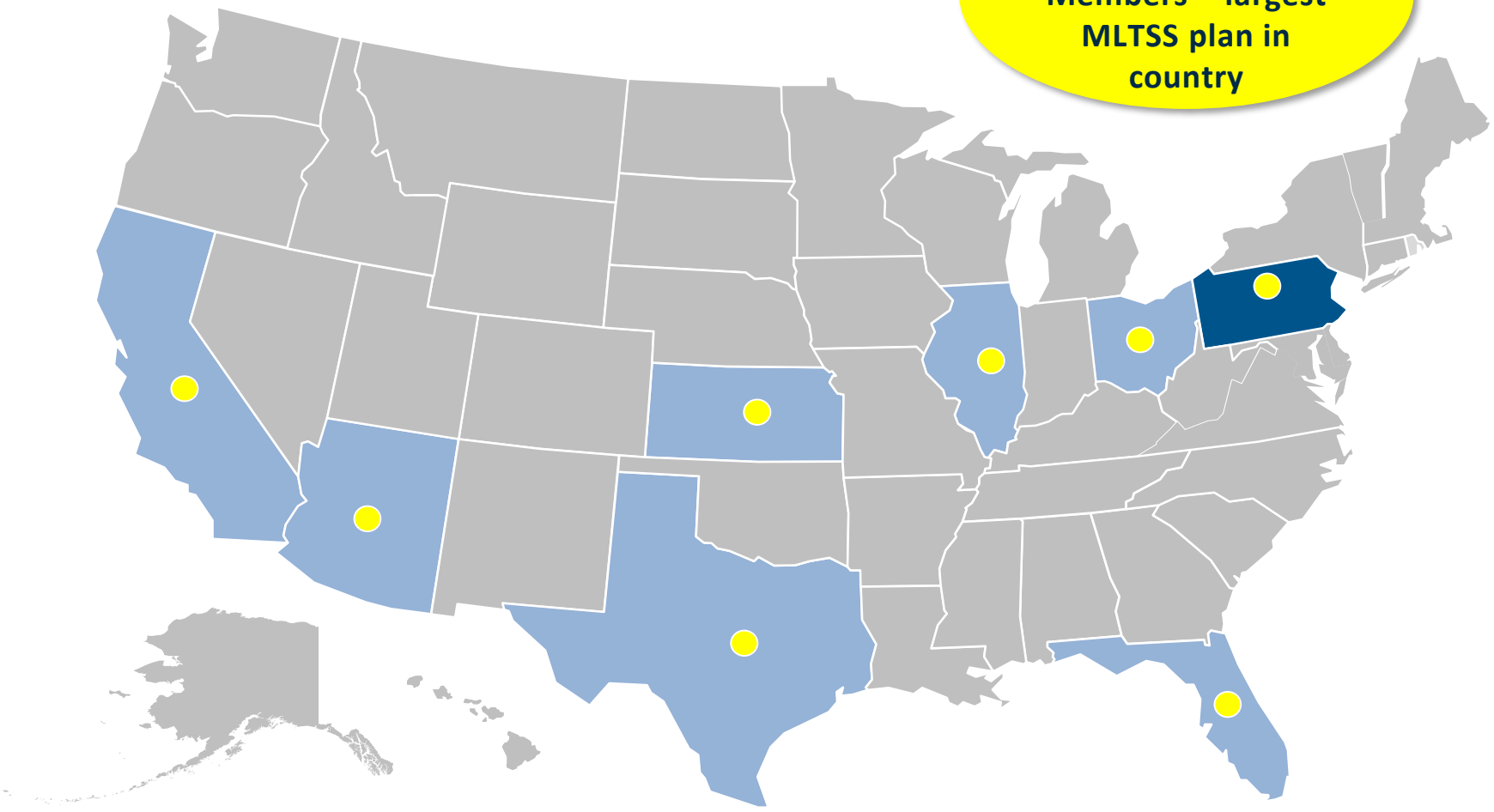
- **Medicaid** (23 states)
- **MLTSS & MMP** (9 States)
- **MA SNP** (6 States)
- **ABD Non-Dual** (17 States)
- **Marketplace** (13 States)
- **Medicare** (13 States)
- **Correctional** (8 States)

12.2 million members in 28 states & 2 international markets

Long-Term Services and Supports

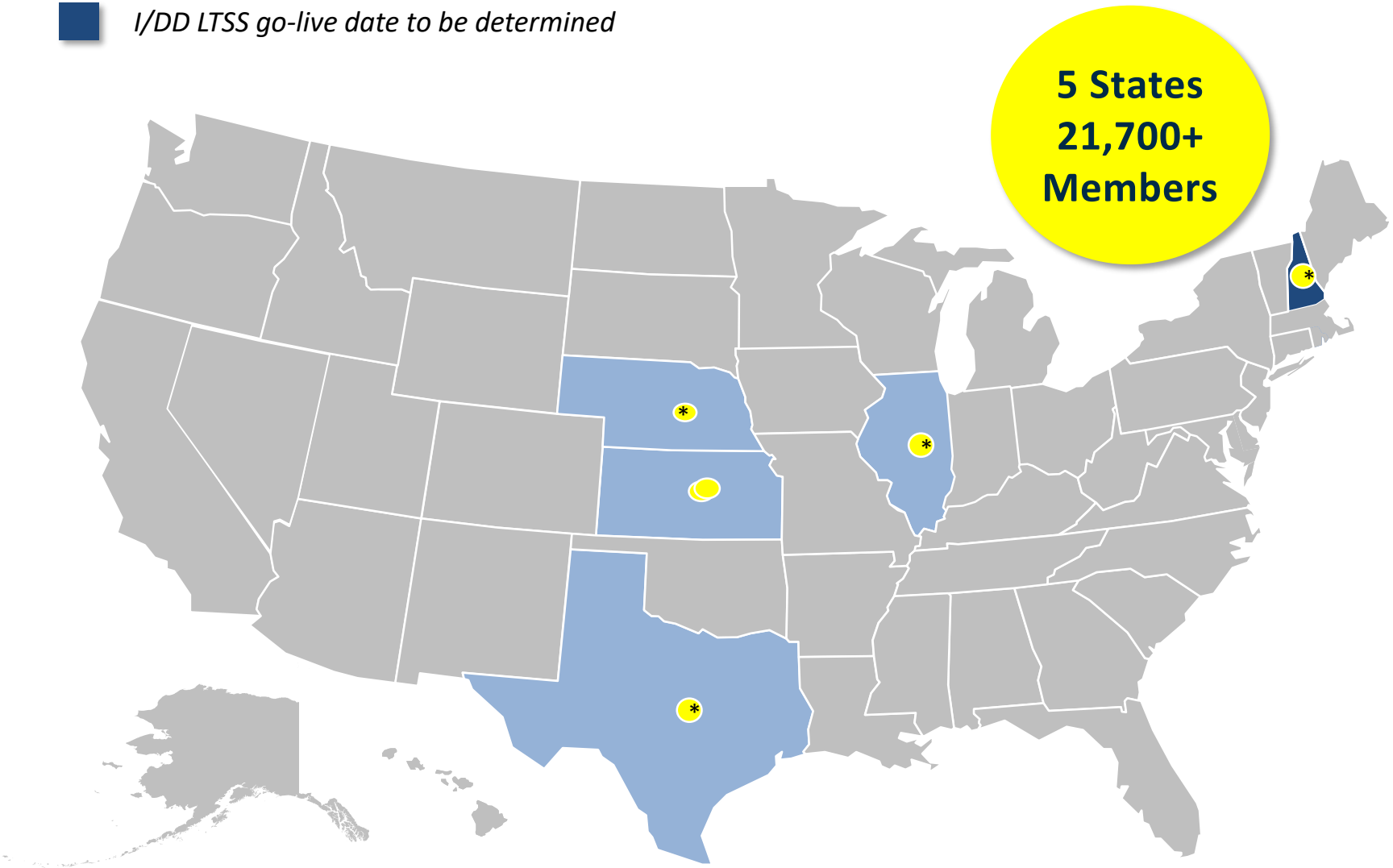
Go live 2018

7 States
213,000
Members – largest MLTSS plan in country



Intellectual and Developmental Disabilities

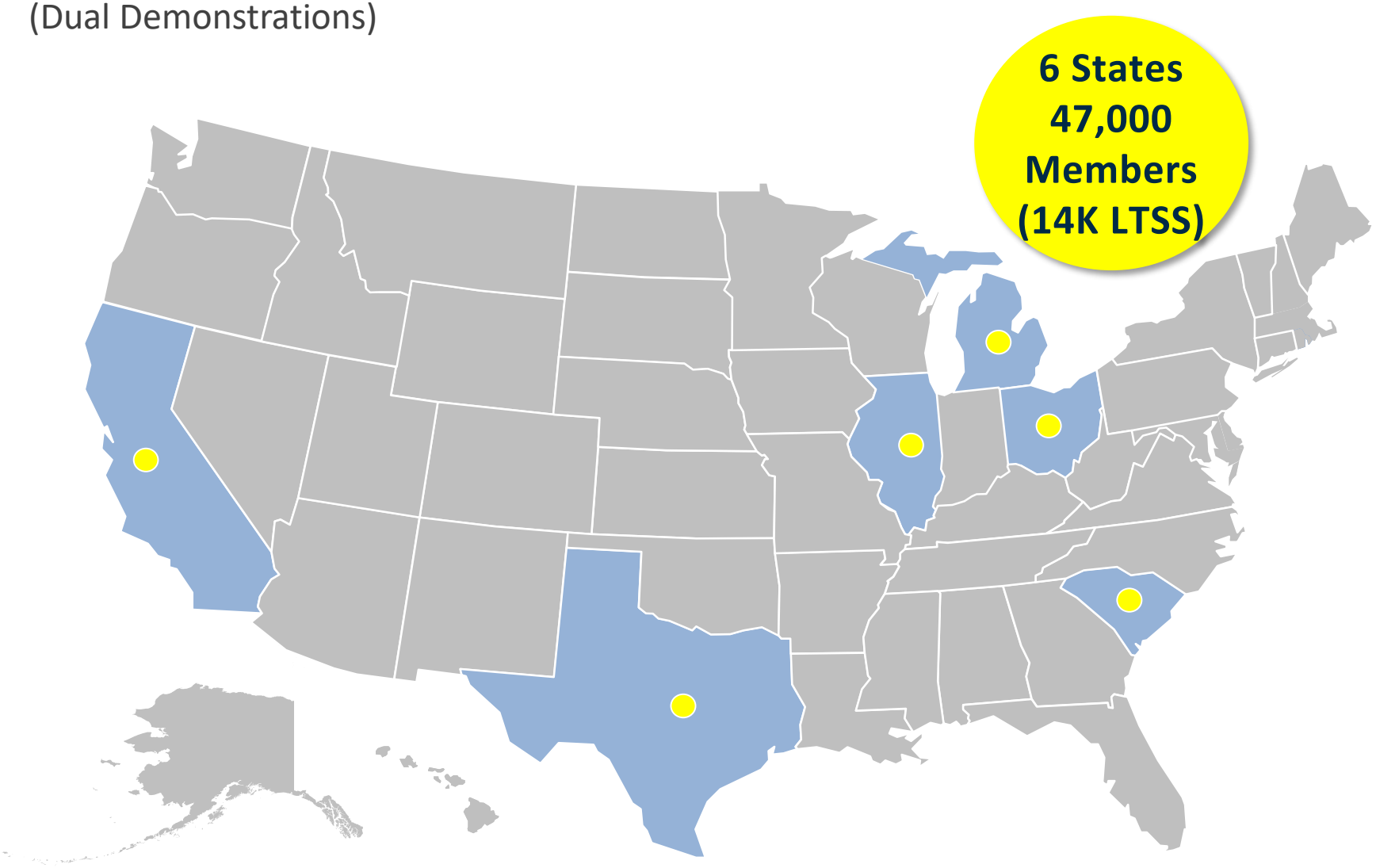
I/DD LTSS go-live date to be determined



* IL, NE, NH and TX cover acute services only; TX also covers habilitation services under the Community First Choice waiver

Medicare Medicaid Plans

(Dual Demonstrations)



HCBS services where network adequacy is difficult to measure

- **Personal attendant services/Direct Service Professionals**
- **Home delivered meals**
- **DME/Supplies**
- **Employment supports**
- **Habilitation services**
- **Skilled nursing and therapies**
- **Home modifications**
- **Assistive technology**

Matching supply and demand is hard

Personal Attendant /Direct Service Worker example

Factor	Issue
Supply of workers	• How many workers are available at any given moment in time
	• How many hours will a given worker be available?
Demand for workers	• How many hours will be required per member and when (mostly at program start-up)
	• What specific preferences will members have for worker (e.g., cultural, gender, etc) (mostly at program start-up)

Possible measures for services coming to the home

Measure	Description
Time to placement	• Time from initial request for service to when initially delivered • Longer the time to placement, weaker the adequacy
Missed visits	• Number of scheduled visits that do not occur (excluding those cancelled by member) • Higher number of missed visits, weaker adequacy
Late visits	• Number of scheduled visits that start more than 30 minutes (or another agreed to time) after scheduled time (excluding those changed by member) • Higher number of late visits, weaker adequacy

What's the right path for self-direction?

- How do you measure "adequacy" when the member can choose from anyone?
- How do you ensure that you honor the member's key role as the decision-maker and employer?
- To what degree is EVV appropriate or even feasible?

Convene stakeholders to gain input into the key self-direction questions on whether they received services:

1. At the right time
2. In the appropriate amount
3. At the appropriate level
4. In the appropriate place

Potential tools required to implement

Electronic Visit Verification

- Allows for time stamps on arrival and departure
- Provides ability to match scheduled time of service with actual delivery of service

Registries for Individual Providers

- Allows for a potential market to develop
- Provides for deeper “pool” of consumer directed options by allowing IP’s to work for multiple consumers
- Exists in some markets via CILs but not pervasive

We can’t ignore the underlying structural issues…

Wages for personal attendants are low and non-competitive

Career paths for personal attendants are limited

Joint employer issues

…And additional barriers to implementing HCBS network adequacy measures

Barrier	Potential resolution
Provider resistance to using EVV	• Ensure providers are compensated for costs/make it free • Create teeth for lack of use • Ensure "open EVV" so easy for providers to work with multiple plans
Determining what is "good"	• Separate rural and urban • Begin with relative performance and raise bar from there

HEALTH MANAGEMENT ASSOCIATES

Innovative Approaches to HCBS Network Adequacy in MLTSS - Findings

National HCBS Conference

Sarah Barth

August 29, 2017

HMA

HEALTH MANAGEMENT ASSOCIATES

OUR FIRM

We are a leading independent, national healthcare research and consulting firm providing technical and analytical services.

We specialize in publicly-funded health programs, system reform and public policy.

We work with purchasers, providers, policy-makers, program evaluators, investors and others.

Our strength is in our people, and the experience they bring to the most complex issues, problems, or opportunities.

RESEARCH METHODOLOGY

- **Research funded by the Medicaid and CHIP Payment and Access Commission (MACPAC)**
- Conducted comprehensive literature review
- Reviewed 33 contracts in 23 states
- Conducted 12 interviews to understand how HCBS network adequacy standards have evolved
  - Medicaid officials in 4 states (MN, TN, TX and VA)
  - 2 managed care associations and selection of MLTSS member plans (Association of Community Affiliated Plans and National MLTSS Health Plan Association)
  - 3 provider organizations
  - 3 consumer advocacy groups

RESULTS OF CONTRACT REVIEW

- Literature review and contract reviews identified 44 types of standards related to HCBS network adequacy
- Most common HCBS network adequacy standards related to:
  - Time and distance
  - Continuity of care

Other frequently used HCBS network adequacy requirements

- Monitor gaps in service
- Contract with any willing provider
- Procedures for single case agreements
- Contract with minimum number of providers
- Reimburse at fee-for-service rates

RESULTS OF CONTRACT REVIEW

- 14 contracts required plans to monitor gaps in service
  - Required tracking and reporting of instances when an individual was authorized to receive a service, but the service was not provided on time or at all
  - Some states and plans use electronic visit verification systems to identify gaps in service
  - States often require back-up or contingency plans for gaps in service

RESULTS OF CONTRACT REVIEW

- States generally applied network adequacy measures to all HCBS provider types, but some included measures specific to certain providers *(e.g., personal care services)*
  - Most often service gap measures and back-up plans
- Three states (DE, TN and NJ) required plans to submit annual network adequacy plans that describe their existing provider network, how they monitor the timeliness of care, and how they will address deficiencies

- Unique HCBS network adequacy standards:
  - Telemedicine: Promote innovation in service delivery system by using technology innovation in target areas, enabling the use of telemedicine to stretch and extend HCBS network (PA)
  - Rural considerations: Consider specific characteristics of and accommodations for HCBS providers traveling to rural areas, taking distance LTSS workers must travel into account (VA)

INTERVIEW THEMES

- Stakeholders identified goals for HCBS network adequacy
  - Ensuring individuals have opportunities for self-direction and meaningful choice of providers
  - Contracting with providers with cultural competencies in the individual's cultural, linguistic, cognitive and disability related needs
  - Measuring outcomes and quality of life
  - Promoting high quality services and supports

INTERVIEW THEMES

- Provider capacity is a limiting factor in HCBS network development
  - HCBS provider shortages (e.g. direct care workers such as personal care attendants)
- 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
- 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 individuals are getting the care they need, and have been authorized to receive

CONCLUSION

- MLTSS HCBS network adequacy standards are evolving to account for characteristics distinct to HCBS providers and the individuals they support in the community
- States are increasingly monitoring:
  - Meaningful choice of provider
  - Capacity of HCBS providers to serve individuals in their homes
  - Timeliness of service provision by tracking gaps in services
- Several states are requiring network adequacy plans related to HCBS
- Stakeholder goals include incorporating cultural competency and quality as factors for HCBS network adequacy
- Stakeholders did not feel that compliance with the April 2016 Medicaid Managed Care provisions on HCBS network adequacy would be a challenge

MACPAC

Innovative Approaches to HCBS Network Adequacy in MLTSS

Medicaid and CHIP Payment and Access Commission

Kristal Vardaman

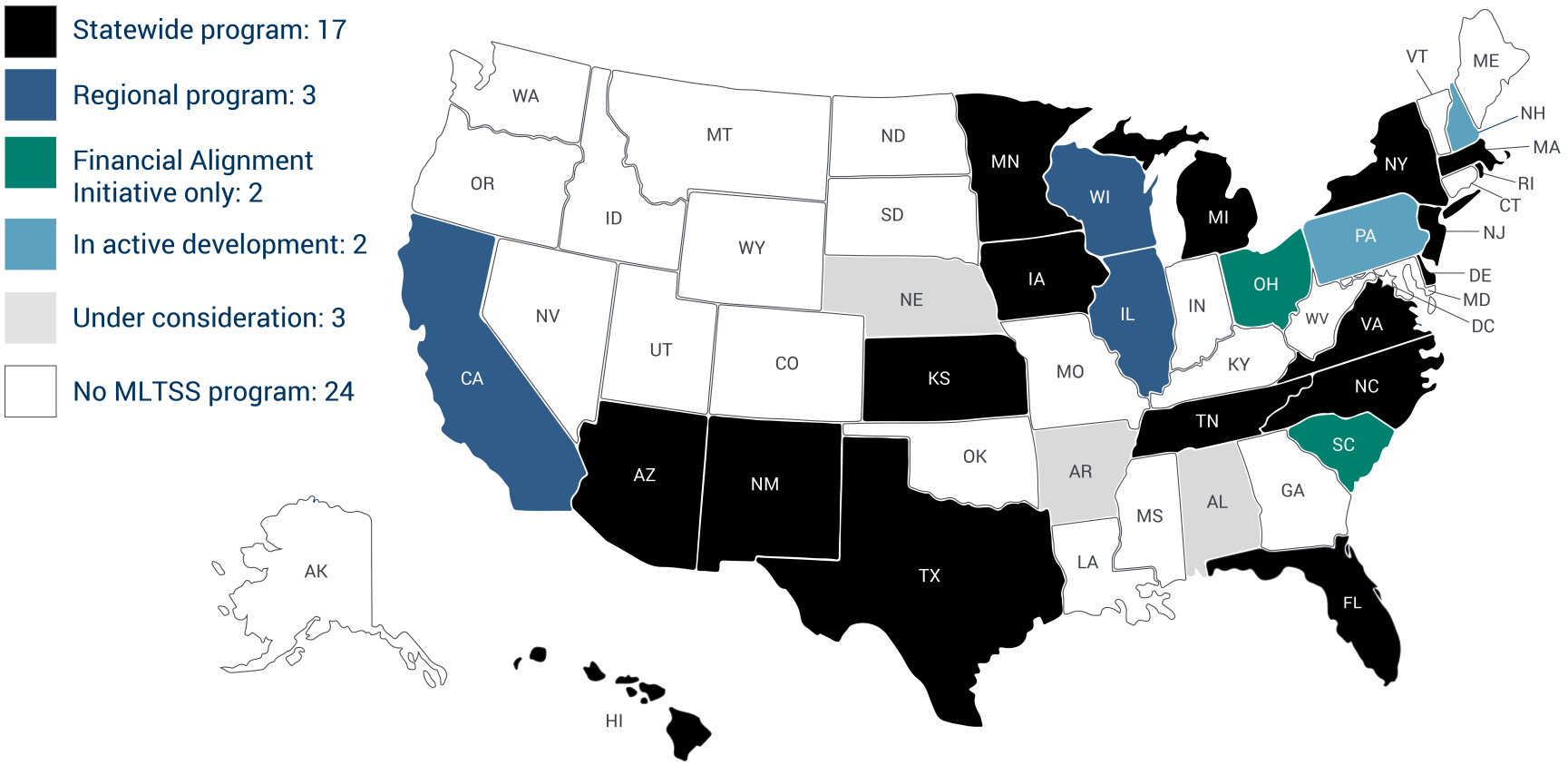
Overview

- Introductions
- Status of managed long-term services and supports (MLTSS) adoption
- Background on network adequacy standards for home and community-based services (HCBS)
- Results of MACPAC-funded research
- State perspective: Virginia
- Plan perspective: Centene
- Questions

Speakers

- Kristal Vardaman, MACPAC
  - Background and federal requirements
- Sarah Barth, Health Management Associates
  - Results of MACPAC-funded research on HCBS network adequacy standards
- Karen Kimsey, Virginia Department of Medical Assistance Services
  - Development of HCBS network adequacy standards for a recently launched statewide MLTSS program
- Michael Monson, Centene Corporation
  - Plan perspective on standards and tools needed for implementation

State Adoption of MLTSS, July 2017



Source: National Association of States United for Aging and Disabilities 2017.

Network Adequacy Concerns for HCBS Differs from Acute Care

Issue	Acute care services	Home and community-based services
Travel required	Beneficiary travels to provider to receive care	Provider often travels to beneficiary
Time period of services	Mostly short-term	Long-term, need could last for years or decades
Provider capacity	Some concerns, particularly for certain specialties and in certain geographic areas	Widespread concern with growing demand
Provider contracting issues	Providers generally familiar with managed care contracting	Providers in states transitioning to MLTSS are unfamiliar with managed care contracting

Use of 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
  - 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 review MLTSS contracts and conduct stakeholder interviews
- Key questions
  - What HCBS network adequacy standards exist in current contracts?
  - How have network adequacy standards evolved in states with well-established programs?
  - To what extent will states need to develop additional standards in response to the rule?

MACPAC

Innovative Approaches to HCBS Network Adequacy in MLTSS

Medicaid and CHIP Payment and Access Commission

Kristal Vardaman