

Managed Long-Term Services and Supports

Assessing Provider Network Adequacy



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The rapid expansion of Managed Long-Term Services and Supports (MLTSS) programs throughout the country has created new challenges for Medicaid policy makers seeking to ensure that health plans meet the needs of people with disabilities and older adults who receive Long-Term Services and Supports (LTSS). Many health plans taking on MLTSS responsibilities for the first time may be unused to LTSS-specific member needs and provider networks, creating a risk that networks may not be sufficient to meet the needs of members. As the number of MLTSS programs continues to increase, it becomes all the more important for states to have LTSS-specific provider network adequacy standards in Medicaid Managed Care contracts.

On April 25, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a Final Rule on Medicaid Managed Care. Among other contract provisions was a requirement that states put in place network adequacy standards for LTSS providers. Although states were initially required to introduce time and distance standards for eleven types of non-LTSS providers (a requirement that

the Trump Administration has since proposed revoking), CMS deliberately left open how states would introduce network adequacy standards for LTSS providers, citing uncertainty as to how such standards would be constructed: “The few number of comments and lack of consensus regarding the measure of network adequacy for services when a provider travels to the enrollee confirm our position that states should establish standards based on their unique mix of services and characteristics and evaluate and amend these standards.”

In short, while time and distance standards represent a promising practice for measuring network adequacy for many non-LTSS providers, the decentralized nature of Home and Community-Based Services (which constitute the majority of LTSS in most states), and the fact that many HCBS providers travel to an individual’s home rather than service recipients traveling to provider facilities, have presented real difficulties for policymakers and advocates seeking to determine the most appropriate means of measuring network adequacy for LTSS providers.

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States must take into account strategies to ensure the health and welfare of enrollees using LTSS and to support community integration of people receiving LTSS. This policy brief is designed to offer policymakers and advocates options for consideration in designing MLTSS frameworks with robust network adequacy provisions. States must consider the broad scope of LTSS providers in developing network adequacy rules, including institutional, community-based, residential and employment supports, depending on the scope of the managed care program. It is worth noting that states may wish to adopt different provider network adequacy standards for different kinds of LTSS providers and even for different geographic regions within a state, both of which are explicitly allowed for within the Medicaid Managed Care rule.

The scope of this report is limited to Home and Community Based Services (HCBS) providers, rather than institutional providers. The report outlines multiple options that are available to state policymakers seeking to evaluate network adequacy for HCBS providers under MLTSS programs. It makes the case that not all types of HCBS can be measured by the same types of provider network adequacy standards. In particular, while the bulk of existing LTSS provider network adequacy standards focus on agency providers, self-directed services – which generally rely on an independent provider network – may require new, more innovative approaches to assessing network adequacy. Similarly, there is a marked difference between HCBS providers that come to a member’s home and those that deliver services at a fixed site.

Phase-In Provider Network Requirements

Many states require health plans to attempt to contract with all or most agency providers in a given category during the initial phase-

in period of the MLTSS framework, recognizing that insufficient network adequacy during this transitional period may be particularly damaging to members and the overall success of the MLTSS program. These phase-in requirements are designed to minimize the disruption members face as they transition into managed care.

In addition, they also serve to assist Medicaid providers in managing the transition to a service environment in which reimbursement and invoices must go through multiple different health plans. This is a particularly crucial need for LTSS agency providers, who – unlike providers of acute medical services – likely only have experience with Medicaid as a payer. As a result, the transition from a single, state-operated billing process to multiple billing processes managed by different health plans may create significant administrative challenges. This has the potential to result in provider agency consolidation, the merging of existing providers or the going out of business of providers not able to manage the administrative burdens of the new service environment. Provider consolidation can harm people with disabilities by reducing choice and limiting the ability of new entrants to the field of LTSS service-provision.

Compared to physician’s offices and hospitals, LTSS agency providers are likely inexperienced at negotiating rates with health plans. By giving providers added leverage through more robust network adequacy requirements on health plans in the initial phase-in, states can mitigate the risk of provider consolidation and assist smaller providers in building the business acumen necessary to survive and thrive in an MLTSS environment. This is particularly important for HCBS agency providers, given that many of the most innovative, least restrictive types of HCBS, such as supported community living and supported

employment services, are disproportionately dependent on small agency providers. To help smaller agency providers transition into MLTSS, states should consider offering sample billing sessions, introducing providers to key health plan officials and standardizing administrative requirements across health plans. These measures will reduce the disruption associated with moving into a multi-payer environment for small HCBS agency providers.

If MLTSS leads to significant provider consolidation, it may disrupt efforts to promote positive systems change towards services provided in a person's own home rather than congregate service settings.

States should impose more robust network adequacy requirements on health plans for an initial phase-in period after the launch of a new MLTSS program or the carve-in of a new population into an existing MLTSS program. Such an approach will increase the ability of HCBS providers to manage the transition from a fee-for-service system into an MLTSS program.

A variety of options exist for these phase-in network adequacy requirements. Iowa requires that plans give all HCBS waiver agency providers (with the exception of case managers and care coordinators) and all 1915(i) HCBS Habilitation Services agency providers a chance to enroll in the plan's provider network. Plans are required to document at least three attempts to offer a reasonable rate as part of the contracting process, though they may recommend disenrollment of providers not meeting defined performance measures agreed to with the state (with the state ultimately maintaining final authority for review and approval of disenrollment recommendations). South Carolina's dual eligible demonstration required that all willing HCBS providers that currently serve program beneficiaries be offered a contract

for the first year of the demonstration, and set minimum reimbursement requirements for such contracts. Illinois' dual eligible demonstration required that health plans maintain a network that included providers that delivered at least 80% of the services delivered under Fee for Service (FFS) during the first year of the demonstration.

Because states are still working to develop adequate LTSS provider network adequacy standards, importance should be placed on the plan's policies for enabling enrollees to access out-of-network HCBS providers that are important to a member's continued residence or employment in the community. In states that are maintaining a non-managed care Medicaid system, reimbursement rates for out of network providers can be determined by benchmarking rates for such arrangements to existing Medicaid rates for LTSS providers. For example, under Ohio's dual eligible demonstration, plans are required to reimburse an out-of-network provider at the Medicare or Medicaid FFS rate applicable for the service, during the first year of plan operations. However, for states that do not maintain a parallel FFS Medicaid LTSS system, this is not a viable benchmark, given the absence of a Medicare FFS rate for most LTSS.

Alternatively, states can target out-of-network provider protections to those members who are most at risk of finding themselves in need of an out-of-network provider: members who have recently enrolled in a new plan or whose provider has recently exited a plan's provider network. States may wish to offer a continuity-of-care period for new members who have just enrolled with a health plan. For example, Virginia's CCC+ program requires plans to pay for a provider's services during the first 90 days of a member's enrollment when the provider has an existing relationship with the member, regardless of whether that provider is in-network.

Under the Massachusetts dual eligible demonstration, when a member changes MCOs, the new MCO must honor a previously authorized service plan until a new service plan is implemented. This includes paying providers the same rates as before that member became a part of the new MCO. Virginia's dual eligible demonstration requires that MCOs must honor all existing service plans and authorizations until the authorizations end or 180 days after the member's enrollment, whichever is sooner. As part of this provision, members newly enrolled in the demo can retain their current providers until 180 days after enrollment, regardless of whether they are in-network. Members who are switching from another plan retain this right for 30 days. **States should require health plans to honor existing service plans, including rates for out-of-network providers, for an appropriate transition period for members who are recently enrolled or are impacted by the loss of a provider from the MCO's provider network.**

These provisions are largely oriented around maintaining an adequate network of agency providers during the transition to managed care. **With respect to independent providers of self-directed services, states should require that health plans contract with all available FMS or fiscal intermediary providers during the transition period.** On a long term basis, states should look to service fulfillment and provider ratio standards (discussed in detail later in the report) to ensure that health plans are reimbursing for self-directed services at a rate sufficient to allow it to remain a viable option for those receiving LTSS.

Travel Standards

While time and distance standards are not particularly relevant for most HCBS providers who travel to a member's home, they are nonetheless incorporated into some MLTSS contracts. As of 2017, approximately half of all state MLTSS programs maintained a network adequacy standard based on travel distance, and 38% maintained one based on travel time¹. It is not uncommon for different parts of a state to operate under different network adequacy standards. Idaho requires plans to contract with at least two community LTSS providers within 30 minutes or 30 miles of a member within certain counties and 45 minutes or 45 miles within other counties. Virginia's dual eligible demonstration requires a choice of at least 2 providers for each service type within 30 minutes of travel time for members in urban areas and within 60 minutes of travel time for members in rural areas.

Time and distance standards may help ensure network adequacy in agency-directed HCBS, but are inadequate measures of network adequacy for independent providers, who typically provide self-directed services. Under self-direction, hundreds or thousands of independent providers may operate in a single area, and their adequacy depends on the number of service hours needing to be filled compared to the availability of workers to provide those services. Since agency providers can scale to meet available need, while independent providers are only able to provide a limited number of service hours, different mechanisms are needed to assess network adequacy for self-direction (see service fulfillment and provider ratio standard sections below).

¹ <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

Some states introduce time and distance standards specific to out-of-home placements - for example, Iowa, Tennessee and several other states require plans to make a good faith effort to ensure that no more than 60 miles separate a member's "community-based residential alternative placement" from the member's residence before entering the facility, presumably to maximize continued community and family relationships after a person goes into a group home or assisted living facility. Delaware maintains a similar requirement, set at 30 miles (reflecting the smaller size of the state). **When plans must resort to out-of-home placements, distance standards represent an important promising practice that states should consider to maintain natural support networks and increase the likelihood that members will be able to transition back to non-provider owned or controlled settings in the future.**

To avoid unnecessary out-of-home placement, however, such standards for out-of-home service provision must be coupled with similarly robust standards for in-home services. If states require a more robust network adequacy standard for out-of-home congregate settings than for in-home supports, individuals may be inappropriately funneled into out-of-home placements due to the greater availability of local providers for such service-provision. **States should mitigate this risk by coupling such requirements with standards designed for in-home services, such as service fulfillment standards and provider ratio data standards.**

Regardless of the nature of the travel standard used to ascertain network adequacy, states should issue a publicly available scorecard reflecting the percentage of each county's health plan membership that has access to a choice of provider under the network adequacy standard.

Because time and distance standards require administrative capacity to implement, typically states will only monitor them for a subset of providers. This usually means that only a select few LTSS provider categories will be tracked. Because time and distance standards fit more naturally with congregate providers, for which the member travels to the provider rather than having services delivered within the member's home, institutional or other congregate provider types are disproportionately likely to be tracked under travel standards for network adequacy. This obviously presents a serious challenge for the non-congregate HCBS models that most align with the broader values framework that disability rights advocates promote.

In order to adequately assess provider network adequacy for services delivered in a member's home, states must consider network adequacy standards other than time and distance. While network adequacy standards for LTSS are in their infancy, as CMS acknowledged, putting in place meaningful requirements on health plans to ensure LTSS network adequacy remains one of the most important policy decisions a state can make in designing their MLTSS program. The second half of this report focuses on the policy options available to states in considering standards other than time and distance for evaluating LTSS network adequacy.

Choice Standards

The most common network adequacy standard used in existing state MLTSS contracts is a choice standard, requiring a certain number of HCBS providers to be available within a particular service region (often a county). As of 2017, 65% of state MLTSS programs maintained a network adequacy standard based on provider

choice.² Florida, Hawaii, Idaho, Illinois, Kansas, Massachusetts, Michigan, New Jersey, New York and several other states have adopted this type of “choice” standard for evaluating network adequacy for HCBS providers.

The most common formulation is a requirement that members have access to at least two HCBS providers of each provider type per service region (again, this standard is most likely only relevant to agency providers). For example, MLTSS programs in New Jersey, Kansas and several other states require a minimum of two providers of each type of HCBS per county. In larger states, larger service regions are often used. Occasionally, exceptions are made for certain provider categories allowing narrower networks. For example, Virginia requires only one provider for assistive technology, environmental modifications, personal emergency response systems, and durable medical equipment and supplies - services in which some level of provider consolidation or congregation are not necessarily as harmful to members as in other areas of HCBS.

At times, choice standards are integrated into travel standards. For example, New York's dual eligible demonstration requires that participants have a choice of at least two providers within a 15-mile radius or within 30 minutes from the participant's zip code. Massachusetts' OneCare program requires at least two community LTSS providers per covered service within a 15-mile or 30-minute radius of each member's zip code of residence, unless the Medicaid agency offers a waiver of this requirement. In other states, choice standards are coupled with a requirement that health plans enroll providers serving a certain percentage of the

MLTSS program's members in a given service region. For example, Illinois requires plans to contract with at least two providers for each LTSS service, and ensure that at least 80 percent of each county's members receiving LTSS prior to the transition to MLTSS will continue service without interruption. This represents an important promising practice for new state MLTSS programs.

Choice standards are overwhelmingly the most common measure used by states to evaluate LTSS network adequacy, likely due to their administrative simplicity. However, they are likely more useful for certain kinds of services than others. For example, since choice standards typically do not vary the number of providers in an area based on the amount of the membership or evaluate the extent to which the providers in a network have adequate capacity to scale to meet the needs of the plan's membership, they represent an insufficient tool for ensuring that members have real choice in their HCBS needs.

These challenges can be mitigated somewhat by coupling a choice standard with a requirement that plans enroll providers serving a certain percentage of the total number of service recipients in a service region prior to the launch of MLTSS, similar to the Illinois requirement. **During the first several years after transitioning to MLTSS, states should consider requiring plans to maintain a provider network covering providers who served at least 80 percent of a service region's service recipients prior to the launch of the MLTSS program.**

Nonetheless, even with this supplemental requirement, choice standards are limited in

²<https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

their usefulness as an ongoing metric of provider network adequacy, especially after the initial launch of an MLTSS program. Since provider agencies often limit their acceptance of new clients without closing, maintaining networks based solely on the requirement that at least two agencies be within a network for each provider type will not address the question of whether or not members have a choice of provider.

In addition, there may be significant variation in the expertise offered by each agency. Particularly for the most innovative forms of service-provision targeting complex populations, such as shared living/host homes, supported community living, community-based day habilitation and supported employment, there may be dramatic differences between provider agencies. Some may specialize in serving individuals with medically complex needs, significant behavioral challenges or specific cultural or linguistic needs. Choice standards do not account for any of those differences between providers within the same broad provider category.

Choice standards offer an administratively simple way of ascertaining whether or not a plan is in compliance with network adequacy standards, but may be inadequate to meet the actual needs of members to have a choice of providers or access to any provider capable of meeting their needs. Choice standards that set a specific number of providers that must be available in a given geographic area, but do not vary based on the amount of member need in that geographic area, may be insufficient to ensure that members receive a real choice of provider. To address this, states must turn to network adequacy standards that evaluate

member experience or are scalable based on the number of members and the intensity of their service need in a given geographic area.

Service Fulfillment Standards

Of those network adequacy standards now in use, service fulfillment standards are the most useful for in-home services. Service fulfillment standards typically measure some version of the gap between services authorized and services received. This gap is evaluated either in terms of the length of time that passes between the initial authorization of a service and the initial fulfillment of it, or the gap between the amount of services authorized and the amount of services delivered. As of 2017, 31% of state MLTSS programs made use of service fulfillment standards (sometimes referred to as service initiation standards)³.

Fourteen state contracts require health plans to monitor for gaps in service, including reporting of instances in which a beneficiary was authorized for a service but it was not provided.⁴ The forthcoming implementation of the Electronic Visit Verification mandate may afford an opportunity to better monitor these gaps between service authorizations and service delivery in a more systematic way.

A variety of options exist for network adequacy standards that make use of service gap data. The most straightforward is measuring the amount of time between authorization and initial delivery of a service. Recognizing the high rate of turnover in direct support work, states may also wish to track service gaps after the initial delivery of service, potentially by measuring the number of hours or days of

³ <https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>

⁴ <https://www.macpac.gov/wp-content/uploads/2017/04/Managed-Long-Term-Services-and-Supports-Network-Adequacy-for-Home-and-Community-Based-Services.pdf>

service a member receives in a given year as compared to the number of hours or days of service a member is authorized to receive.

There are advantages to each of the types of service fulfillment standard. Measures that focus on the length of time between a member being authorized to receive services and their initial receipt of services are particularly useful for evaluating the extent to which a plan's care coordination, assessment and authorization infrastructure are well plugged into the local provider network. A well-run MLTSS program will likely be able to initiate service in relatively short order after it is authorized, as case management staff will be familiar with the local providers and will be able to work with the member to connect them with appropriate options immediately after authorization. A poorly run MLTSS program may feature plans that do not maintain case management staff with strong local provider relationships and knowledge, or who have poor coordination between provider networks and case management staff for other reasons (such as inadequate provider networks or overly high case manager caseloads). **States should incorporate time from authorization to service fulfillment as a measure of network adequacy in all state MLTSS contracts.**

However, as important as this measure is, it is insufficient to evaluate ongoing network adequacy. Members may start receiving services, but be unable to continue them due to the low quality, unreliability or exit from a plan's network of a particular provider. One of the most important aspects of meaningful network adequacy is the member's ability - for the full duration of their enrollment - to pick a different provider if they so desire. This is not only necessary for adequate service-provision, it is vital for quality service provision. The availability of other provider options

increases the quality with which providers work to serve a member, and the member's ability to exit increases their willingness to demand high-quality service provision from their provider on the basis of basic disability rights principles of self-determination, autonomy, community integration and respect.

As a result, states must also incorporate measures that compare the amount of services authorized to the amount of services actually delivered as a measure of network adequacy in all state MLTSS contracts. Measures that focus on this gap between the amount or duration of authorized service provision and the actual services delivered offer a tool for measuring both network adequacy and the impact of network adequacy on service quality. Many members may be receiving a substandard quality of direct support as a result of an insufficient or inappropriate workforce. As a result, measuring the number of missed visits or late visits may represent an important metric of network adequacy, which the implementation of the EVV mandate may shed light on. Similarly, measuring the gap between authorized services and services delivered may be a particularly useful tool for evaluating network adequacy in self-directed services, an area that remains a significant shortcoming in most state MLTSS contract measures of network adequacy.

Provider Ratio Standards

For some categories of HCBS, the number of agencies in a service area may not be a useful measure of network adequacy. Since attendant care and other similar forms of in-home services are often delivered by self-employed "independent providers," a fundamentally different approach to network adequacy may be required than that used for acute services or LTSS from a licensed provider. When dealing with providers of in-home personal assistance and related

services, the number of individual workers is more important than the number of agencies offering services. This is particularly the case for self-directed services, for which a single Financial Management Services entity often manages self-directed services program- or statewide.

As such, states should consider adopting network adequacy standards that evaluate the total number of direct support professionals in a given geographic area relative to member need. CMS references such an approach as a possibility within the Managed Care Final Rule, noting that states may wish to consider “direct care provider ratios to LTSS beneficiary service plan hours.” Such an approach has many advantages. By measuring the number of workers rather than the number of agencies, states would be offering a far more meaningful measure of network adequacy for service categories for which the quality of service-provision depends primarily on the availability and quality of the individual worker.

States can take a number of approaches to ascertaining the appropriate ratio of direct support professionals to authorized service plan hours. When an existing data system allows for effective pre- and post-MLTSS comparisons, states could set network adequacy standard using the ratio present under the FFS system. However, given workforce shortages in many areas, states may wish to seek a more ambitious ratio, based on the assessed needs of people with disabilities authorized to receive LTSS in their service area. Additional research may be necessary to ascertain the appropriate ratio of direct support professionals to authorized service hours in order to establish a baseline for LTSS network adequacy for individual providers. Given the different competencies associated with different kinds of service provision to different populations, states may wish to set distinct data-based

network adequacy requirements for different service categories.

A ratio of direct support professionals to authorized service hours would incentivize health plans to set rates at a level adequate to recruit and maintain an adequate workforce to meet the needs of beneficiaries. In the past, an approach that required information on the total number of direct support professionals serving a given population may have been too administratively difficult to implement. However, a number of key developments have put in place a data infrastructure that can be used to measure network adequacy.

Many states have background check requirements for particular categories of service-provision. Some simply require agency providers to conduct background checks, while others maintain state-administered background check systems and abuse registries. Where states administer their own background check and abuse registry processes, they have an exact count of the number of authorized workers in a given geographic area. Self-directed services also offer an opportunity for a precise worker count, because Financial Management Services entities are typically required to perform a background check prior to allowing a worker to deliver services. However, while these counts may provide information on the number of authorized workers in a service area, they do not necessarily give accurate information on the number of available workers in a service area. The rate of turnover in attendant care and direct support work is extremely high, with many workers exiting the field for other industries. As a result, the number of workers authorized to deliver services likely significantly overestimates the number of workers available to deliver services.

Where background checks must be renewed on a regular basis, this worker count is

somewhat more up to date. Where background checks do not have a renewal requirement, the worker count will likely dramatically overstate the number of workers eligible to deliver services, due to workers leaving the field. States should account for this in setting an appropriate ratio of eligible direct support professionals to service hours authorized, recognizing the need for a higher ratio for programs that do not require regular background check renewals. For self-directed services, a better measure can be obtained from the FMS provider or providers by using the number of workers drawing a paycheck within a twelve-month period. **For self-directed service provision, we recommend the use of worker pay data from the FMS provider or providers as the primary data source for evaluating network adequacy, along with authorized service hours.**

Self-directed services also offer another potential complication - namely, that a significant percentage of workers delivering services to self-directing members may be family members who have limited to no interest in delivering services to members outside their own family. **Workers who are providing services only to relatives should generally not be counted in calculating ratios of available workers to members.** Within the context of self-directed services, states may also wish to require that health plans maintain a Matching Service Registry and use the presence of eligible direct support professionals seeking additional employment within the registry as a measure of network adequacy. A Matching Service Registry is a platform that helps connect people with disabilities and workers, usually through an online or telephone interface.

There are positives and negatives associated with relying on a Matching Service Registry for evaluating network adequacy. Many workers who are unfamiliar with the Internet or who find that they can locate adequate

employment through word of mouth or newspaper classified ads may not create profiles on a registry, thus resulting in an undercount of the available workforce. However, given that many workers will join the support workforce only to provide services to a friend or neighbor, an analysis of FMS pay data may overestimate the available workforce, even after discounting the family workforce from the estimated provider ratio. States may wish to consider both metrics as complementary measures. Alternatively, states may wish to require workers to create a profile in the Matching Service Registry.

Such an approach is in line with a growing body of promising practices that recommend the use of Matching Service Registries for self-directed services and certain forms of individualized agency-directed services. **Using data from background check and abuse registry databases along with Matching Service Registries, states should develop network adequacy standards for individualized, in-home services in which individual workers serve as the main providers of service. Such standards should be implemented on a county or region-wide basis, rather than statewide, recognizing the different geographic concentrations of members and service-providers throughout a state.**

States may also wish to embed linguistic competency requirements within such network adequacy standards, thereby increasing the likelihood that members from monolingual immigrant communities will have access to direct support professionals able to meet their needs. Similarly, when certain types of credentials or training may be useful but not required as a prerequisite for delivering services in a program, states may wish to set goals for plans to meet (potentially tied to quality measures) for a percentage of workers able to meet such

requirements within a particular HCBS program.

Utilizing data from background check or Matching Service Registry databases to ascertain network adequacy may require some modifications to the existing implementation of background checks and other pre-employment eligibility requirements. For example, most states currently require a worker to have an employer willing to hire them prior to initiating a background check process and abuse registry check. This approach is understandable, given the expense of that process to the state or health plan. However, it likely reduces the utility of the background check database and the Matching Service Registry as a tool to evaluate network adequacy, since workers may only join it after they have already been hired by their first client. **States should modify their FMS requirements in MLTSS contracts to allow workers to receive prospective background checks and abuse registry checks, enabling them to show up as eligible to be hired in a Matching Service Registry or background check database prior to finding an employer. Such an approach would significantly improve the utility of this data for evaluating network adequacy.**

Oversight and Enforcement

Most oversight of network adequacy is conducted based on data provided by the health plans on the availability of providers. The introduction of Provider Ratio Standards may provide a more objective means of the state evaluating network adequacy, but for most existing network adequacy standards, data is primarily collected by the health plan. One notable exception is the existence of secret shopper programs, used by Tennessee within its MLTSS program and in many other states for measuring network adequacy for medical services. A number of states use secret

shopper programs to evaluate the degree to which plans are maintaining adequate provider networks. These secret shopper efforts are commonplace in acute care services and have been recommended as a promising practice by a number of advocacy groups, including Justice in Aging and Community Catalyst. Nonetheless, while secret shopper programs are a common component of state contracts, they are not as effective as surveying members to ask them about how difficult it is for them to locate a provider. Such a survey could be incorporated into the larger quality measurement framework adopted by the MLTSS program.

For plans that do not meet network adequacy requirements, a variety of options exist for states. At the most extreme, states may choose to end their managed care contract with a plan or end the managed care program altogether, as Connecticut did in 2011, in part over concerns regarding network adequacy. This alternative, while dramatic, is considered unlikely and thus should not be viewed as an adequate recourse to ensure plans maintain adequate networks. Few states are willing to end a Medicaid managed care program once it begins and returns to FFS from MLTSS have been few and far between.

States may also consider prohibiting plans out of compliance with network adequacy standards from enrolling new members, a significant penalty given the importance of new member growth in achieving, maintaining or increasing plan profitability. In 2018, Illinois sanctioned Blue Cross and Blue Shield of Illinois, citing its failure to meet network adequacy standards for certain rural parts of the state and to adequately respond to grievances and appeals. Some state MLTSS contracts, including the Wisconsin FamilyCare MLTSS program, reference this as a potential remedy for plan violations. This option may represent a more

viable penalty, because it does not require the state to reconstruct a FFS infrastructure from scratch. However, it may prove disruptive to members who will have fewer plan options to choose from, and is a severe penalty that states may prove reluctant to impose except under very limited circumstances.

As a result, financial penalties are the most viable alternative for states seeking to sanction plans for failing to meet network adequacy requirements. Tennessee's contract allows the state to impose a penalty of \$25,000/quarter should the plan fail to meet network adequacy standards. Texas' managed care contracts allow the state to assess \$1,000/quarter per service area and provider type found out of compliance with the network adequacy requirement. These types of financial penalties are representative of those found in other MLTSS contracts.

These penalties are remarkably low for contracts that frequently encompass hundreds of millions, and at times billions, of dollars of contracted services. Given the substantial costs associated with new provider network development and the potential for cost savings to the plan by disincentivizing the enrollment of high-cost members through inadequate provider networks, more serious penalties appear to be necessary in order to meaningfully influence plan behavior. **States should set financial penalties for failure to meet**

network adequacy at a level sufficient to incentivize appropriate plan behavior. In addition, states should consider incorporating network adequacy as a factor within the quality measures used by the state to award dollars from the MLTSS program's quality withhold incentive program, should one exist.

Conclusion

States have a wide variety of options to measure network adequacy for LTSS providers, consistent with the requirements of the federal Medicaid Managed Care rule. Given the extraordinary diversity of LTSS and HCBS providers, it is likely that states will need to adopt multiple measures embedded into different components of the MLTSS contract in order to adequately incentivize plans to develop and maintain adequate provider networks to meet members' LTSS needs. States must adopt different network adequacy approaches for different service categories and populations, recognizing the diversity of need within the MLTSS population. States should ensure that they are monitoring these issues on an ongoing basis, both in the initial phase-in process and across the full scope of the managed care contract. As MLTSS continues to expand across the country, developing and implementing a framework for LTSS network adequacy is particularly crucial to ensuring that MLTSS can improve, rather than harm, HCBS availability and quality.