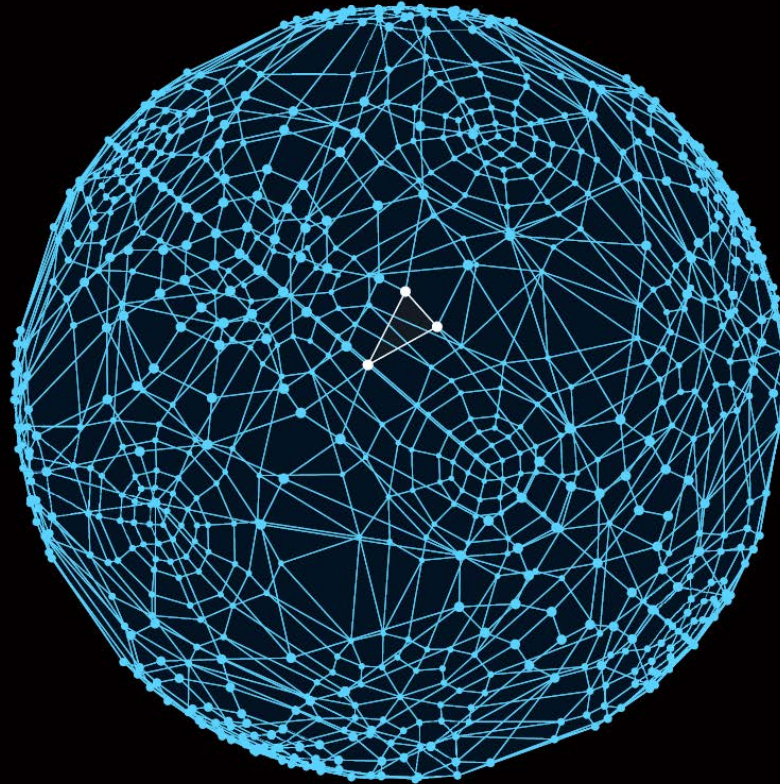


Deloitte.



**Evaluating HCBS Network Adequacy
National HCBS Conference 2018, Baltimore**

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WHAT IS PA COMMUNITY HEALTHCHOICES (CHC)?

A Medicaid managed care program that will include physical health benefits and long-term services and supports (LTSS). The program is referred to nationally as a managed long-term services and supports program (MLTSS).

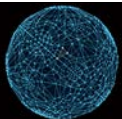
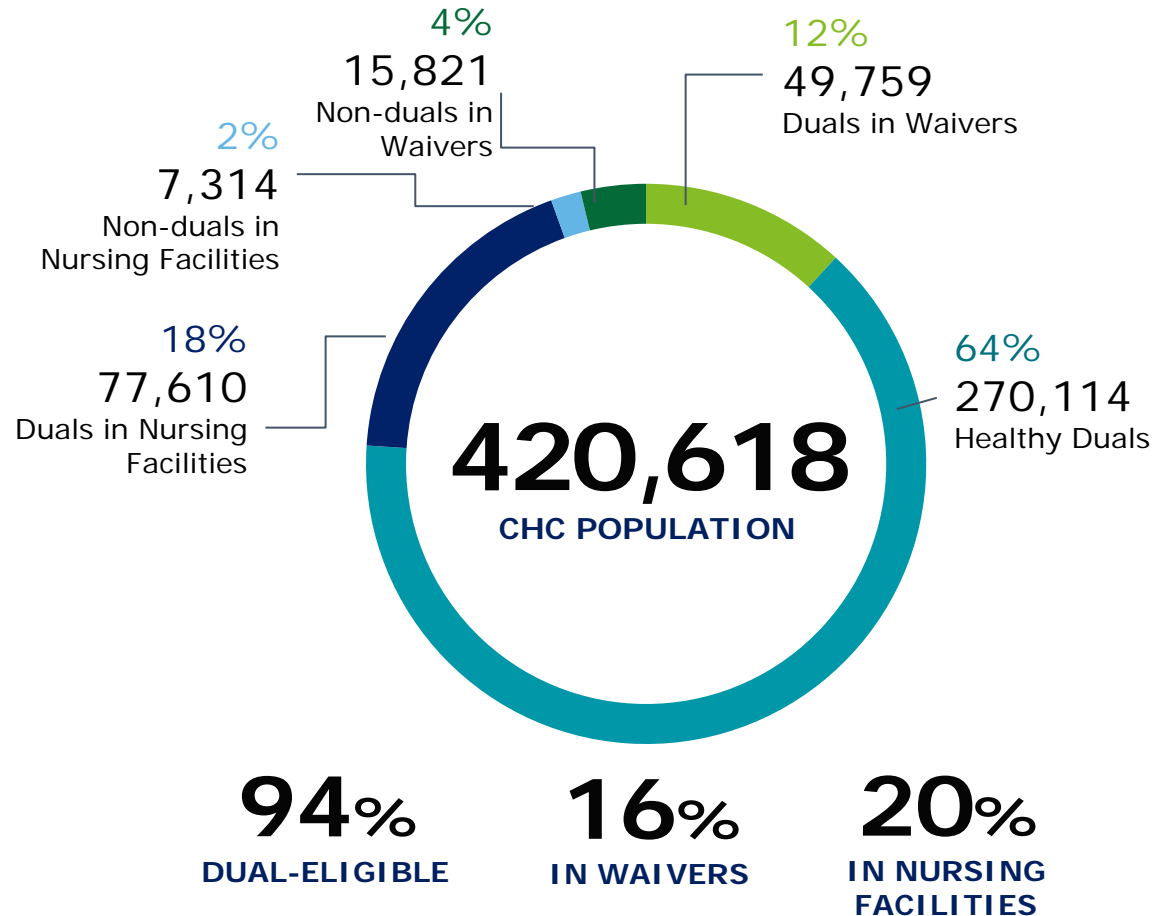
Who is part of CHC?

- Individuals who are 21 years of age or older and dually eligible for Medicare and Medicaid.
- Individuals who are 21 years of age or older and eligible for Medicaid (LTSS) because they need the level of care provided by a nursing facility.

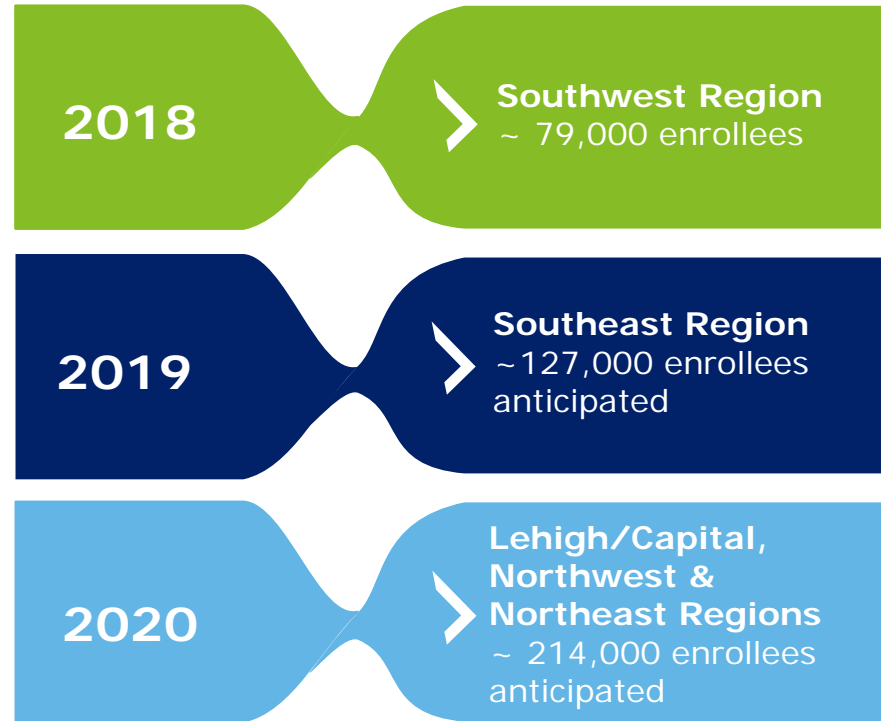
What are the goals of CHC?

1. Enhance opportunities for community-based living.
2. Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid based services for dual eligible participants.
3. Enhance quality and accountability.
4. Advance program innovation.
5. Increase efficiency and effectiveness.

Who is in the CHC population?



CHC IMPLEMENTATION STATUS



SOUTHWEST

SOUTHEAST

LEHIGH/CAPITAL, NORTHWEST & NORTHEAST

JANUARY 2018

Allegheny
Armstrong
Beaver
Bedford
Blair
Butler
Cambria
Fayette

JANUARY 2019

Bucks
Chester
Delaware
Montgomery
Philadelphia

JANUARY 2020

Adams	Franklin	Northampton
Berks	Fulton	Northumberland
Bradford	Huntingdon	Perry
Cameron	Jefferson	Pike
Carbon	Juniata	Potter
Centre	Lackawanna	Schuylkill
Clarion	Lancaster	Snyder
Clearfield	Lebanon	Sullivan

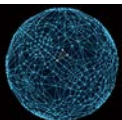
Priorities through Implementation

Continuity of Care

- MCOs are required to contract with all willing and qualified providers for 180 days after CHC implementation.
- Participants may keep their existing providers for 180 days after CHC implementation.

Service Coordination

- Every participant receiving LTSS will choose a service coordinator who coordinate Medicare, LTSS, physical health services, and behavioral health services.
- Each participant will have a person-centered planning team that includes their doctors, service providers, and natural supports.



CHC LESSONS LEARNED FROM PHASE 1

Enhanced communication materials and training regarding Medicare vs CHC

Earlier stakeholder engagement opportunities

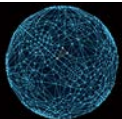
Earlier data clean-up in HCSIS and SAMS

MCO Provider Training and outreach to occur earlier and more often

More education and communication on continuity-of-care

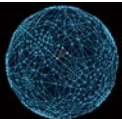
Earlier OBRA reassessments

Earlier pre-transition notices





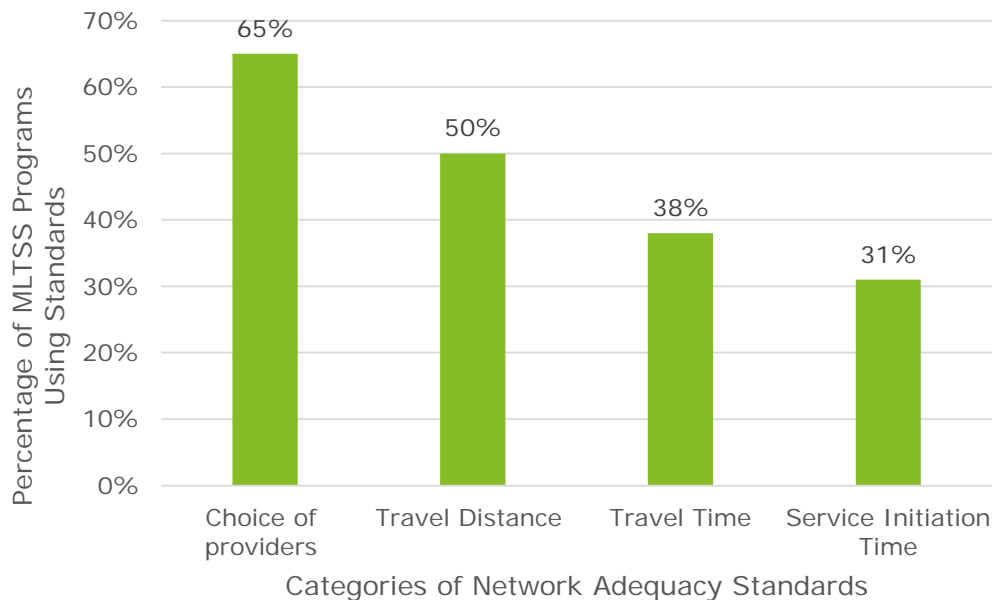
HCBS Network Adequacy Oversight



NATIONAL APPROACHES TO EVALUATING HCBS NETWORK ADEQUACY

“ States which cover LTSS must develop network adequacy standards other than time and distance standards for LTSS provider types that travel to the enrollee to deliver services. ”
CFR 438.69
- Medicaid Final Rule, 2016

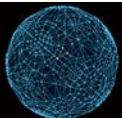
Typical HCBS Network Adequacy Methods



Challenges

1. An HCBS provider can have any number of employees, and counties have different populations.
2. Travel time criteria do not apply because services are provided in a participant's home or in a community setting.
3. Service initiation criteria do not measure long term network adequacy.

Source: Truven Health Analytics report for the Centers for Medicare & Medicaid Services
<https://www.medicare.gov/medicaid/managed-care/downloads/ltss/mltssp-inventory-update-2017.pdf>



EVALUATING PHYSICAL HEALTH NETWORK ADEQUACY IN PA

Network adequacy refers to the availability of providers in a network to provide in a timely manner the services required by the participants served by the network

Provider Network Information

MCOs submit Provider Network information



Network Adequacy



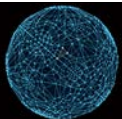
Participant Location Information

Office of Long Term Living (OLTL) generates file with aggregated CHC participant data

Network Adequacy Criteria

Requirements regarding minimum number of providers and maximum duration of travel time for each provider type and County

For HCBS services, the traditional network adequacy standards based on the participant traveling to the providers location do not apply since services are provided in a participant's home or in a community setting



COLLECTING PROVIDER NETWORK DATA IN PA

Standardized Provider Network File

- A standardized mechanism and format is used by all MCOs to submit provider network data to both the states Independent Enrollment Broker to be displayed on the participant facing provider directory and to DHS
- Addresses lack of consistency in data provided by MCOs

Automated Data Validation Processes

- Automated processes ensuring MCOs are following data quality and completeness standards
- Provides a way to validate data provided by MCOs

Accurate Data for Analysis and Visualizations

- Provider network data can be quickly and accurately analyzed and visualized
- Reduces amount of staff time devoted to answering simple business questions

Standardized Provider Network Submission File:

- Weekly report listing all providers within the MCO's network
- Column requirements specify content, data type, and length
- These column requirements and validations performed are consistent across MCOs



DEVELOPING AN APPROACH TO HCBS NETWORK ADEQUACY

A work group was created including multiple stakeholder groups where the different typical HCBS approaches to network adequacy were reviewed and deemed in sufficient to meet stakeholder concerns

Stakeholder Engagement



Decision to Use FTE Ratios

- DHS and stakeholders agreed that an approach using the number of actual direct care workers available to participants would provide a more precise way to measure HCBS network adequacy and support the oversight needed to reduce risks to the CHC participant population
- Based on this decision an approach using a ratio of participants to Full Time Equivalents available was developed



PA APPROACH TO HCBS NETWORK ADEQUACY

1

Review Historical Service Plan Information

Service plan data from services provided prior to CHC implementation used to develop the minimum required ratio of provider full-time equivalents (FTE) to CHC participants

2

Define Network Adequacy Criteria

Criteria is defined on the County, provider type, and specialty level using the resulting minimum FTE ratios

3

Report Requirements

MCOs collect FTE information from providers and then include this in the network information submitted to OLTL. MCOs must update FTE information at least once per year.

4

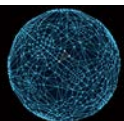
Evaluate Network Adequacy

Participant location and provider network information are used to evaluate network adequacy in comparison to the network adequacy criteria

5

Review and Update FTE Ratios

Moving forward OLTL will review actual service usage based on encounter claims and feedback from stakeholders and update FTE ratios



ADOPTION CONSIDERATIONS

Preparation

- Determine services to evaluate and collect FTE data on
- MCO surveying of providers to confirm available direct care works on a county by county basis
- Specify validation rules for new data in provider network file from MCOs

Implementation

- Tracking MCO compliance with FTE data submission rules
- Supporting MCO and provider questions on
- Timing of FTE data updates from MCOs

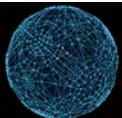
Monitoring

- Monitoring changes in provider networks and continuity of care ends
- Monitor and support compliance for MCOs data submission
 - Reports on submission rates
 - View validation error reports



Adoption Was Supported by Affordable Care Act Provider Revalidation Requirements

The ACA requires screening for all providers upon enrolling in the medical assistance program, adding a new service location, or revalidating enrollment. This requirement aids in collection of accurate provider network data.

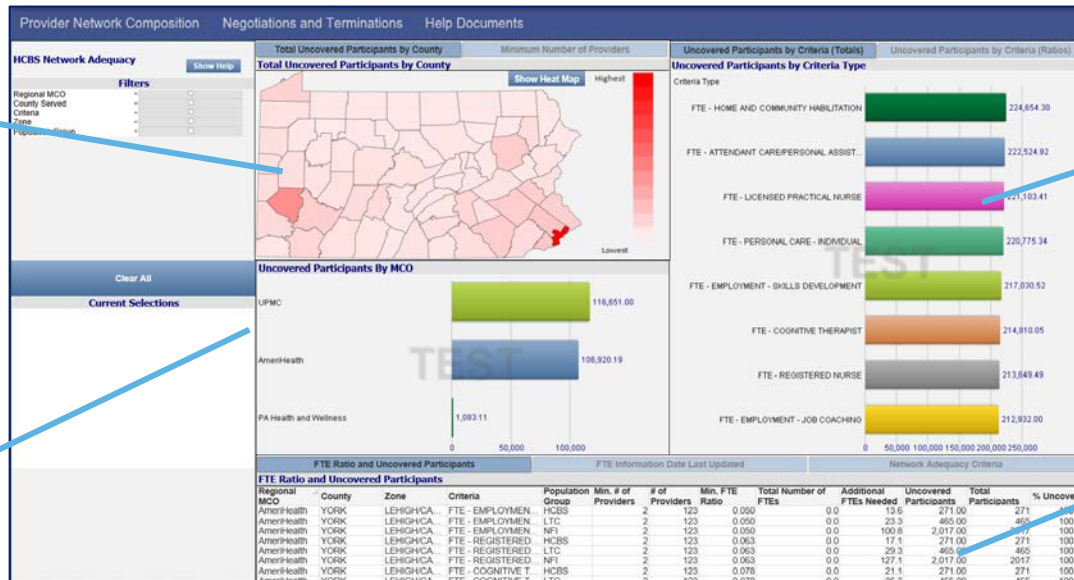


VISUALIZATION OF NETWORK ADEQUACY

In Pennsylvania, a cloud-based solution has been implemented to measure and oversee each MCO's provider network composition and network adequacy

Heat map shows density of uncovered participants by county

Number of uncovered participants broken down by MCO



Number of uncovered participants and percent uncovered by network adequacy criteria

View metrics, such as Total Number of FTEs, Additional FTEs Needed, and Uncovered Participants for each MCO, network adequacy criteria and county

Note – Data displayed is for demonstration purposes only

Example Uses

- Identify number of uncovered participants per County
- Calculate percentage of uncovered participants for each provider type and specialty
- Determine additional number of FTEs required to meet network adequacy requirements
- Identify provider types and specialties with the highest number of uncovered participants

CHALLENGES



FTE reporting must be standardized across each MCO and providers



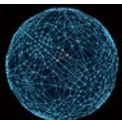
Calculating FTE ratios requires accurate historical data on service usage. Once CHC is implemented statewide, the MCOs will maintain this data instead of OLTL.








Data collection process requires close coordination between MCOs and providers to collect accurate FTE information



Working with MCOs on questions concerning how direct care workers who provide more than one service, such as home health and home care, should be reported



NEXT STEPS

-  Continue to refine minimum FTE ratios for each County, provider type and specialty using service plan data for CHC zones that have not gone live
-  Continuing to support the adoption of MCO FTE data submission
-  Utilize HCBS Network Adequacy tools to identify gaps in each MCO's provider network
-  Adding HCBS validation and review questions to Access to Care studies and targeting studies on HCBS providers
-  Encounter analysis to evaluate minimum FTE ratios



PRESENTER CONTACT INFORMATION

Jill Vovakes

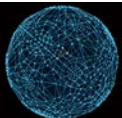
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