



Promising Practices in Managed Long-Term Services and Supports: Network Adequacy and Accessibility

February 15, 2019

BRANDEIS UNIVERSITY

The Heller School

FOR SOCIAL POLICY AND MANAGEMENT

The Lurie Institute
for Disability Policy

Community Living Policy Center

- Aims to advance policies and practices that promote community living outcomes for individuals with disabilities of all ages through research and knowledge translation.
- Rehabilitation Research and Training Center funded by the National Institute for Disability, Independent Living, and Rehabilitation Research (NIDILRR) within the Administration for Community Living, U.S. Department of Health and Human Services (Grant #s 90RTCP0004 and 90RT5026).



Community Living Policy Center Partners

- Lurie Institute for Disability Policy at Brandeis University
- University of California, San Francisco (UCSF)
- Association of University Centers on Disabilities (AUCD)
- Autistic Self Advocacy Network (ASAN)
- Disability Rights Education & Defense Fund (DREDF)
- Disability Policy Consortium (DPC)
- Centene Corporation
- National Association of States United for Aging and Disabilities (NASUAD)
- Mike Oxford, Topeka Independent Living Resource Center
- Henry Claypool, National Policy Expert
- Disability and Aging Collaborative



Promising Practices in MLTSS

Five reports now available at communitylivingpolicy.org:

- Assessing network provider adequacy
- Promoting physical and programmatic accessibility
- Transition & diversion from institutional placement
- Assessment, authorization, service planning, and case management
- Using capitation to promote home and community-based services

Webinar Logistics

- Everyone will receive by email:
 - Copy of the power point
 - Archived recording
- Webinar is being live captioned
- Time for questions following speakers
 - Submit questions via the Chat function

Presenters

Ari Ne'eman

Community Living Policy Center



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Disability Rights Education and
Defense Fund



Managed Long Term Services and Supports: Protecting Community Living within Managed Care

Ari Ne'eman

Background on Provider Network Adequacy

- Key component of well-designed managed care contracts;
- Holds MCOs to a quantitative standard of provider access;
- Insufficient provider network adequacy can mean insurance coverage is meaningless
- 2016 Managed Care Rule required states to adopt network adequacy provisions – including for LTSS
- Time and Distance Standards Usually Inappropriate for LTSS

Network Requirements During Phase-In

- Shift to MLTSS often very disruptive for smaller LTSS providers;
- Stronger Network Requirements During the Phase-In Mitigate This:
 - Iowa: Requires at least three attempts to offer a reasonable rate;
 - South Carolina Duals: Requires all eligible HCBS providers to be offered a contract in the first year of the demo;
 - Illinois Duals: Requires plans to have a provider network that encompasses at least 80% of the services delivered under FFS for first year;
 - Virginia CCC+: Requires plans to pay for an out of network provider's services during the first 90 days after enrollment if an existing relationship exists;
 - MA Duals: Plan must honor authorized service plans until a new one is delivered, including the same rates to existing providers;

Network Requirements During Phase-In

- States should adopt more robust network adequacy requirements on plans for the first contract year;
- When members switch plans, states should require plans to honor existing service plans, including providers and rates, until a new authorized service plan is agreed to;
- States should require plans to contract with all FMS entities for an appropriate duration during the transition to MLTSS;

How to Measure Provider Network Adequacy?

- Travel Standards (Time and Distance);
- Choice Standards;
- Service Fulfillment Standards
- Provider Ratio Standards

Travel Standards

- Usually reflected as “time and distance standards”
- The most common form of network adequacy standard for acute care;
- Half of all state MLTSS programs maintain a network adequacy standard based on travel distance, 38% based on travel time.
- Standard may vary based on geography
 - Idaho: Requires plans to contract with at least two HCBS providers within 30 minutes or 30 miles of a member within certain counties, 45 within others.
 - Virginia Duals: Requires choice of two providers for each service type within 30 minutes of travel time for urban, 60 minutes for rural members.

Travel Standards

- Travel standards are inadequate for providers that come to the member's home, non-congregate services & self-direction;
- Distance standards may represent a useful option for out-of-home residential placements, so as to maintain natural support networks;
 - Iowa, Tennessee, others: Requires plans to make good faith effort to ensure that members placed in group homes are within 60 miles of their prior residence;
 - Delaware: Similar requirement, set at 30 miles;
- Important to maintain equally robust standard for in-home residential providers, so as to avoid incentive towards out-of-home placement;

Choice Standards

- The most common form of network adequacy standard for MLTSS contracts – 65% of state MLTSS programs use a choice standard;
- Most common formulation is a requirement of 2 HCBS providers per provider type in region:
 - NJ, Kansas, others: 2 HCBS providers per type in county;
 - Variations based on service region, provider type
- May be integrated into travel standards:
 - NY Duals: Plans must have a choice of two providers within a 15 mile radius or within 30 minutes of a zip code;

Choice Standards

- Some states set choice standards based on the percentage of members providers served under FFS:
 - Illinois: Requires plans to contract with 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 receive service without interruption.
- States should require plans to maintain a provider network sufficient to offer at least 80% coverage of providers serving pre-MLTSS members.
- Preferable to set number of agency providers, as it accounts for variation in enrollment between counties/regions
- Choice standards often inadequate as they don't account for agency capacity and specialized knowledge.

Service Fulfillment Standards

- Measures gap between service authorization and fulfillment, either in time or amount of services;
 - Length of time from when services are authorized to the first provider visit;
 - Number or percentage of missed visits or unutilized service hours/days/budget/authorization;
 - Important to measure gaps after initiation of service, to reflect problems from staff turnover
- Approximately 31% of state MLTSS programs use service fulfillment standards (sometimes called service initiation);
- EVV may offer an opportunity to implement service fulfillment standards in a more robust way;

Provider Ratio Standards

- In Managed Care Rule, CMS references the possibility of “direct care provider ratios to LTSS beneficiary service plan hours” in LTSS network adequacy
- Compares number of available providers to authorized service hours/beneficiaries.
- No known model to point to – but natural next step for self-direction, other forms of individualized HCBS encouraged by Settings Rule;

Provider Ratio Standards

- Big Question: How to measure the number of authorized providers?
 - For self-direction, could be done via an FMS worker pay data or Matching Services Registry;
 - For any service, could be done via state role in abuse registry & background checks;
 - Workers providing services only to relatives should not be counted in assessing network adequacy
- Offers the opportunity to set a baseline of FFS network adequacy, then create a floor (i.e: 90%) with the possibility of year on year increases to improve above FFS level over time;
- May require the availability of prospective background checks prior to a worker finding someone who wants to hire them.



Disability Rights Education & Defense Fund

Promoting Physical and Programmatic Accessibility in Managed LTSS Programs

Community Living Policy Center Webinar

Mary Lou Breslin - February 2019

3075 Adeline Street, Suite 210 • Berkeley, CA 94703 • 510.644.2555 • 510.841.8645 fax

www.dredf.org

Topics

- Disability health and health care disparities
- Physical and programmatic access
- Federal actions
- Promising practices

Health Disparities

HHS – Advisory Committee on Minority Health – July 2011

- By every measure, persons with disabilities disproportionately and inequitably experience morbidity and mortality associated with unmet health care needs in every sphere. Minorities with disabilities are doubly burdened by their minority status.
- Set the stage for recognizing disability as a bona fide disparities population

Disability, Health and Health Care Disparities

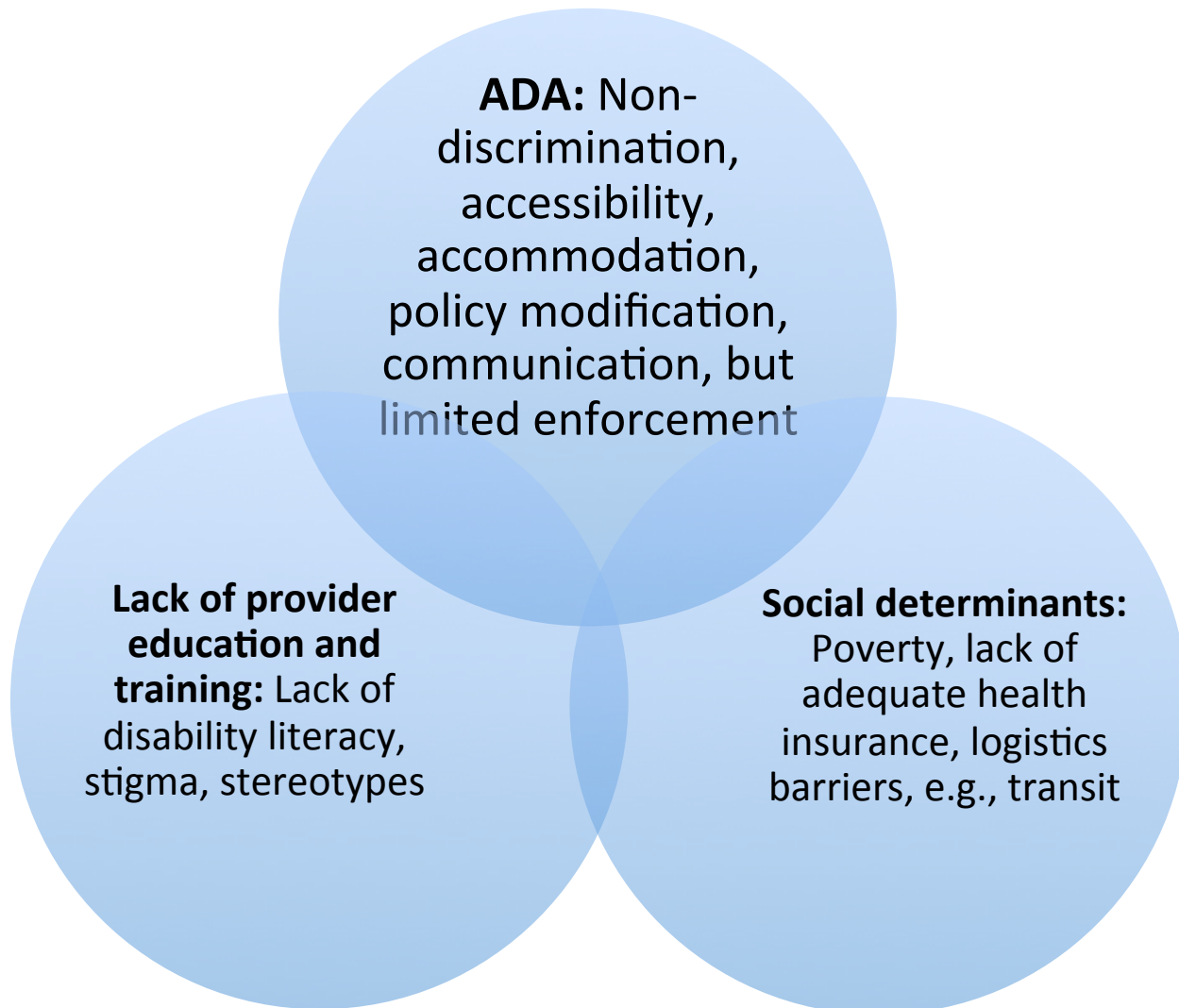
Healthy People 2020

- People with disabilities are more likely to:
 - Experience difficulties or delays in getting the health care they need
 - Not have had an annual dental visit
 - Not have had a mammogram in the past 2 years
 - Not have had a Pap test within the past 3 years

Disability, Health and Health Care Disparities

- Women with disabilities have higher death rates from breast cancer^{*}
- Three out of five people with serious mental illness die 25 years earlier than other individuals, from preventable, co-occurring chronic disease[#]
- Disabled people on Medicare die from lung cancer at higher rates[^]

Why Disparities? Complex Interaction of Factors that Influence Health Status and Health Outcomes for Disabled People



Physical and Programmatic Access

What is Physical Access?

- Practically speaking, physical access means:
 - If parking is provided, wheelchair accessible parking should be available
 - A level entrance into the facility
 - An accessible path within the facility
 - An elevator if offices and services are provided above the first floor
 - Wheelchair accessible restroom
 - Signage for accessibility features
 - Tactile signage

What is Programmatic Access*

- Programmatic access means that the policies and procedures that are part of the delivery of healthcare do not hinder the ability of people with disabilities to receive the same quality of care as other persons
- Where usual healthcare practice may impose barriers, modifications in policy or procedure may be necessary to assure access

Policies and Procedures Needed for Programmatic Access*

- Methods of effectively communicating individual medical information and general health information with patients
- Appointment scheduling procedures and time slots
- Patient treatment by the medical staff
- Awareness of and methods for selecting and purchasing accessible equipment

Policies and Procedures Needed for Programmatic Access*

- Staff training and knowledge (e.g., for operation of accessible equipment, assistance with transfer and dressing, conduct of the exam)
- Standards for referral for tests or other treatment
- System-wide coordination and flexibility to enable access
- Disability cultural awareness

*Nancy R. Mudrick, M.S.W., Ph.D. & Silvia Yee, Esq., "Defining Programmatic Access to Healthcare or People with Disabilities," Disability Rights Education and Defense Fund (DREDF), Berkeley, California, 2007, updated 2014.

Federal Actions

Federal Actions

- HHS – Advisory Committee on Minority Health – July 2011
 - By every measure, persons with disabilities disproportionately and inequitably experience morbidity and mortality associated with unmet health care needs in every sphere.
 - Set the stage for recognizing disability as a bona fide disparities population

Federal Actions

- *CMS Equity Plan for Improving Quality in Medicare - Sept 2015*
 - Six priority areas includes:
 - Increased Physical Accessibility of Health Care Facilities
- 2016 Medicaid Managed Care final rule
 - Accessibility info. in provider directories; network adequacy standards; compliance with contract access, equipment requirements

Federal Actions

- CMS Brief: *Increasing the Physical Accessibility of Health Care Facilities* – May 2017
- ACA established pathways to test new clinical and LTSS models such as the Medicare-Medicaid financial alignment/duals demonstrations
 - (As of 2017, 14 demonstrations operating in 13 states)

Promising Practices

Managed LTSS Contracts

- DREDF/CLPC reviewed nine states' managed LTSS contracts for physical and programmatic access language
 - Six Medicare/Medicaid duals demonstration contracts for:
 - Virginia, Illinois, Massachusetts, Michigan, New York, and South Carolina
 - (Virginia has since concluded its demonstration)
 - Three other Medicaid managed LTSS contracts for:
 - Minnesota, New Mexico, and New Jersey

10 Key Contract Elements

1. ADA/section 504 policies and procedures
2. Provisions for disability awareness and cultural competency
3. Provisions for reasonable accommodation, policy modification, and auxiliary aids and services
4. Responsible person
5. Spell out required actions for health plan, itself

10 Key Contract Elements

6. On-site accessibility review
7. Required assessment of capacity to provide accommodations such as ASL, alternative formats, extend exam time
8. Use of specific accessibility survey tool
9. Compliance plan
10. Access information in provider directory

Key Elements in Duals Demonstration Contracts

- Virginia, Illinois and Massachusetts include 10 elements
- South Carolina and Michigan include nine elements
- New York includes eight elements
 - does not require uniform survey instrument
 - self-assessment/attestations okay

Key Elements in Non-Duals Demonstration Contracts

- New Jersey - most of 10 elements required
- New Mexico includes only six elements
 - Culturally and linguistically sensitive
 - Almost no physical or programmatic access provisions
- Minnesota – only two limited elements
 - Materials in accessible formats
 - Also, accessible information must be readily available
 - Adequate number of providers who serve ASL speakers

Why is This Important?

- Among the six duals contracts-
 - A ground shift in federal expectations and requirements for physical and programmatic accessibility that apply to:
 - managed-care organizations, themselves, and
 - the providers with whom they contract
 - Contracts contain uniform provisions that reflect readiness review process
 - Language an important statement of principles that are built on the social model of disability

Challenges

- Contracts are not self-executing
 - Meaningful implementation involves data collection, monitoring, reporting
- Information on physical and programmatic accessibility of healthcare facilities and services is limited state by state
- No national-level data

Promising Practices

- Emerging community partnerships illustrate possible paths forward
- Two examples:
 - California facility site review – all Medicaid managed care organizations must conduct on-site primary care office reviews using standardized survey
 - Centene health plan partners with NCIL

California Facility Site Review

- Medicaid managed care organizations conduct on-site survey of all network primary care offices using 86-item instrument
- DREDF/Syracuse University—summary of FSR data from 5 MCOs—2010 and 2017
- Accessible exam tables and weight scales
 - 2010 data: 2389 primary care provider offices
 - 8.4% -- height-adjustable exam table
 - 3.6% -- accessible weight scale
 - 2017 data: 3993 primary care provider offices
 - 19.1% – height adjustable exam table
 - 10.9% – accessible weight scale

California Facility Site Review

- Physical access
 - Offices are mostly accessible, with small additional improvement over time
 - Increase in accessible exam equipment and accessible toilet rooms
 - Survey provides a meaningful indication of office accessibility, with a replicable methodology

California Facility Site Review

- Concerns
 - Offices with accessible exam tables and weight scales remains very low
 - Other equipment to assist with patients with mobility limitations is extremely scarce
 - Implementation of accessible features requires proactive effort, not simply an audit

Centene Partners with National Council on Independent Living (NCIL)

- Barrier Removal Fund
 - provider accessibility initiative in Illinois, Texas, Ohio
- 52 health providers received grants for barrier removal and purchase of accessible equipment
- 2500 on-site accessibility site reviews conducted with the help of Centers for Independent Living
- More states planned in 2019
- Centene receives CMS Health Equity Awards

Conclusion

- Progress at the federal level acknowledging physical and programmatic access barriers
- Health plans play an important role
- Ongoing problems include:
 - gaps in data collection
 - limited mechanisms for provider training and awareness
 - lack of a tested and validated uniform physical and programmatic access survey
 - no standards for including accommodation (programmatic access) needs in electronic health records

Resources

Resources for Integrated Care, CMS MMCO

<https://www.resourcesforintegratedcare.com/concepts/disability-competent-care>

Core Competencies on Disability for Health Care Education, Ohio State University and Alliance for Disability and Health Care Education

http://nisonger.osu.edu/wp-content/uploads/2018/09/Core-Competencies-on-Disability-PPT_9.2018.pdf

Promoting Physical and Programmatic Accessibility in Managed Long Term Services and Supports Programs

<https://clpc.ucsf.edu/publications/promoting-physical-and-programmatic-accessibility-managed-long-term-services-and>

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