National
MLTSS
Health Plan Association

Model LTSS Performance Measurement and Network Adequacy Standards for States
April 21, 2017

Purpose and Origin

Health plans that contract with states to take the responsibility for and manage long-term services and supports (LTSS) can provide value for persons that use LTSS and their families, as well as for state governments seeking solutions for expanding access, managing LTSS spending, and complying with federal regulatory requirements.

As managed LTSS (MLTSS) plans, we assume a special obligation to ensure people with significant disabilities of all ages receive the supports and services they need to live independently and with dignity of risk in the setting of their choice. Earning the trust of consumers, their families and advocates, and of the elected officials who represent them, is an essential element of success in managing LTSS. To earn this trust and continue to deliver on the promise of integrated care with better outcomes requires comprehensive quality measurement that empowers consumers to make informed choices, ties payment to MLTSS program goals and member outcomes, and drives system change.

While MLTSS plans are required to collect, analyze and report on volumes of data about our members and the services they receive, there are, to date, no generally agreed-upon, national, validated measures to hold us accountable for the quality of those services or to reliably compare our performance state-by-state and nationally. In a recent report to Congress, the Government Accountability Office (GAO) found that most of the states analyzed in the report did not link payments to plan performance on meeting national MLTSS program goals because "standardized measures for long-term services and supports are not available."[1] GAO suggested that "provisions in CMS's new managed care rule could provide an opportunity for more regular and standardized MLTSS data from states."[2]

The 2016 final rule on managed care in Medicaid and the Children's Health Insurance Program (CHIP)[3] issued by CMS requires that states develop:

[1] United States Government Accountability Office (GAO). January 2017. *Medicaid Managed Care: Improved Oversight Needed of Payment Rates for Long-Term Services and Supports*. GAO-17-145.
[2] ibid
[3] 81 *Fed. Reg.* 27498-27901 (May 6, 2016), available at https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

1. **Standard performance measures** for MLTSS plans, effective on or after July 1, 2017, related to quality of life, rebalancing, community integration activities, transitional care, and whether the consumer received the services and supports set forth in the care plan; and

2. **Network adequacy standards** other than time and distance for LTSS providers that travel to a consumer to deliver services, effective on or after July 1, 2018.[4]

According to the GAO report, the Centers for Medicare and Medicaid Services (CMS) noted that, "standardized MLTSS quality measures remain in the early stages of development." [5] There are many initiatives underway to develop and apply uniform national quality measures for LTSS, and home and community-based services (HCBS) in particular, at the National Quality Forum (NQF)[6], the National Committee on Quality Assurance (NCQA)[7], and (CMS)[8], that will eventually come together as a generally-accepted set of quality measures.

While this process moves forward, member companies in the National MLTSS Health Plan Association developed a set of model LTSS performance measures and network adequacy standards in an effort to assist States in complying with the July 1, 2017 and 2018 regulatory deadlines.

To inform the development of the model LTSS performance measures, the Association met with representatives from NQF, NCQA, and CMS, with other stakeholder organizations, and with state and federal regulators to discuss the selection of measures and specifications. The measures are derived from data readily available to us that we can produce without undertaking major new data collection or data processing activities, and begin reporting in the near future to our members, families, advocates, public officials, and the community-at-large.

As government measure development activities proceed, the Association will work with stakeholder organizations, advocates, and government agencies on opportunities to align the measures reported by Association members and incorporate new measures where appropriate. We are implementing these measures with the intent of encouraging more widespread adoption of person-centered quality measures for MLTSS and greater consistency among states in what is measured and reported, and offer ourselves as a resource for states looking to develop a standardized, comprehensive approach to MLTSS performance and network adequacy prior to the federal regulatory deadlines.

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[4] 42 C.F.R. § 438.330 (2016). States must require this comprehensive quality assessment and performance improvement program in all MCO contracts beginning on or after July 1, 2017.

[5] GAO-17-145, p.21.

[6] National Quality Forum. Quality in Home and Community-Based Services to Support Community Living: Priorities for Measure Development. Final Report. September 2016.

[7] NCQA

[8] Mathematica Policy Research. Quality Measure Development and Maintenance for CMS Programs Serving Medicare-Medicaid Enrollees and Medicaid-Only Enrollees: Questions for Public Comment on MLTSS Measures. September 5, 2016.

Model Performance Measures for MLTSS

Domain #1: Quality of Life

Measures:

1. Percent of members able to see their friends and family when they want, and proportion who are not lonely
2. Percent of members able to participate in activities outside of home when and with whom they want
3. Percent of members who are satisfied with where they live
4. Percent of members who are able to make decisions about their everyday lives
5. Percent of members who have a job or volunteer in the community
6. Percent of members who feel safe and know who to talk to if not

Domain #2: Transition to Most Integrated Setting

Measures:

1. Successful Transitions from Short-Stay Institution to Community Setting
2. Successful Transitions from Long-Stay Institution to Community Setting
3. Admission to an institution from the Community
4. Readmission within 30 Days of Hospitalization
5. HCBS vs. Institutional Services

Domain #3: Integration Risk Factors

Measures:

1. Falls with or without injury
2. Wounds new or worsened
3. Urinary Tract Infections
4. Flu Vaccination
5. Pneumococcal Vaccination
6. Adherence to Medication Regimen
7. Members with Class Polypharmacy

Domain #4: Person-Centered Planning and Coordination

Measures:

1. Timely Comprehensive Assessment and Update
2. Timely Comprehensive Care Plan and Update
3. Care Plan Shared Timely

4. Re-Assessment and Care Plan Update After Discharge
5. Transportation Service Level
6. Service Confirmation
7. Timeliness of Start of Attendant Services
8. Percentage of members reporting care plan includes things important to them
9. Percentage of members reporting they are the deciders of what is in their plan
10. Percentage of care plans with services and supports that reflect the member's goals
11. Percentage of members saying the help received from their care manager is excellent, very good, or good

Domain #5: Satisfaction

Measures:

1. Overall Satisfaction with Health Plan Excellent or Above Average
2. Overall Satisfaction with Care Manager Excellent or Above Average
3. Overall Satisfaction with Institutional Provider Excellent or Above Average
4. Overall Satisfaction with Assisted Living (ALF) Provider Excellent or Above Average
5. Overall Satisfaction with Transportation Provider Excellent or Above Average
6. Overall Satisfaction with Adult Day Care Provider Excellent or Above Average
7. Overall Satisfaction with Fiscal Management Agency (FMA)

Model Performance Measures for MLTSS

Domain #1: Quality of Life

The services provided to MLTSS consumers do not necessarily directly impact health outcomes but rather help maintain or improve quality of life so consumers can participate in their communities and engage with friends and family. In line with the National Quality Forum's "Quality in HCBS" final report, the metrics under "Quality of Life" capture the level to which MLTSS consumers have meaningful relationships, are integrated into their communities, make life choices related to housing and employment, choose and control delivery of their services and supports, and feel safe or know where to go if they do not. These measures are drawn from two primary sources: the National Core Indicators – Aging and Disability (NCI-AD)[9], and the CMS Consumer Assessment of Healthcare Providers and Systems for home- and community-based services (CAHPS-HCBS)[10].

[9] The National Core Indicators-Aging and Disabilities (NCI-AD™) is an initiative designed to support states' interest in assessing the performance of their programs and delivery systems in order to improve services for older adults and individuals with physical disabilities. NCI-AD is a collaborative effort between the National Association of States United for Aging and Disabilities (NASUAD) and the Human Services Research Institute (HSRI). See www.nci-ad.org.

[10] The HCBS CAHPS Survey was developed by the Centers for Medicare & Medicaid Services for voluntary use by state Medicaid programs, including both fee-for-service HCBS programs as well as managed long-term services and supports (MLTSS) programs. See: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html

Domain 1: Quality of Life Measures						
Indicator	**1. Percent of members able to see their friends and family when they want, and proportion who are not lonely**	**2. Percent of members able to participate in activities outside of home when and with whom they want**	**3. Percent of members who are satisfied with where they live**	**4. Percent of members who are able to make decisions about their everyday lives**	**5. Percent of members who have a job or volunteer in the community**	**6. Percent of members who feel safe and know who to talk to if not**
Descriptive Information						
Measure Type	Outcome	Outcome	Outcome	Outcome	Outcome	Outcome
Question(s)	Can you see or talk to your friends and family (who do not live with you) when you want to? Yes/Sometimes/No How often do you feel lonely, sad or depressed? No, not often/Sometimes/ Yes, Often Feels Lonely	Are you able to do things you enjoy outside of your home when and with whom you want to? Yes/Sometimes/No	In general, do you like where you are living right now? Yes/No	Are you able to make decisions about your daily routine? Yes/Sometimes/No	Do you have a paid or volunteer job in the community? Drop down: Member has volunteer job / Member has paid job / Member does not have volunteer or paid job and would like to have one / Member not interested in volunteering/working	Do you feel safe in your home/where you live? Yes/No In the last 3 months, was there a person you could talk to if someone hurt you or did something to you that you didn't like? Yes/No/Don't Know/Refused/Unclear
Measure Source	NCI-AD #7 and #67	NCI-AD #48	NCI-AD #2	NCI-AD #47, 59, 60, 41	NCI-AD #53, 55, 57	NCI-AD #35, CAHPS HCBS #64
Tier	2	2	2	2	2	2

Domain #2: Transition to Most Integrated Setting

As a partnership of MLTSS health plans, we are committed to federal and state efforts to rebalance LTSS with more integrated and cost-effective home-and-community based services, and to implementation of the integration mandate in the Americans with Disabilities Act and *Olmstead* Supreme Court decision. In line with the NQF HCBS final report, the metrics under “Transition to Most Integrated Setting” capture the status of MLTSS plan efforts to transition our members to the most integrated setting of their choice. These measures are drawn from several primary sources: State-defined MLTSS contractual measures, Health Effectiveness Data and Information Set (HEDIS) measures, Mathematica Quality Measures for CMS Programs Serving Medicare-Medicaid and Medicaid-Only Enrollees (Mathematica), and information that is readily available from an MLTSS plan’s comprehensive assessment, claims, or encounter data.

Domain 2: Transition to Most Integrated Setting					
Indicator	**1. Successful Transitions from Short-Stay Institution to Community Setting (per 1000)**	**2. Successful Transitions from Long-Stay Institution to Community Setting (per 1000)**	**3. Admission to an institution from the community (per 1000)**	**4. Readmission within 30 Days of Hospitalization**	**5. HCBS vs. Institutional Services**
Descriptive Information					
Measure Type	Outcome	Outcome	Outcome	Outcome	Process
Question(s)	Percentage of institution admissions (nursing facility or ICF/IID) that result in successful discharge to the community (community residence for 30 or more days) within 100 days of admission.	The percentage of MLTSS enrollees who are long-term residents (101 days or more) of institutions (nursing facility or ICF/IID) successfully discharged to the community (community residence for 30 or more days).	The number of admissions to an institution (nursing facility or ICF/IID) from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months.	Percent of members with a hospital readmission within 30 calendar days of discharge.	Percent of members receiving HCBS versus institutional services.
Measure Source	Mathematica	Mathematica	Mathematica	HEDIS	DE MLTSS Plans
Tier	1B	1	1A	1B	1A

Domain #3: Integration Risk Factors

As a partnership of MLTSS health plans, we are committed to federal and state efforts to rebalance LTSS with more integrated and cost-effective home-and-community based services, and to implementation of the integration mandate in the Americans with Disabilities Act and *Olmstead* Supreme Court decision. We recognize that changes in acute health and functioning are a crucial part of measuring the quality of MLTSS since there are a set of medical indicators directly tied to institutionalization and a member's ability to remain independent in the community, such as pressure sores, urinary tract infections, and falls, to name a few. In line with the NQF HCBS final report, the metrics under "Transition-Related Acute Health and Functioning" capture key aspects of a member's acute health and functioning, and the level to which our members are at risk of institutionalization. These measures are drawn from several primary sources: State-defined MLTSS contractual measures, Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS), Medicare Star Rating measures, Health Effectiveness Data and Information Set (HEDIS) measures, PIMA Part D Pharmacy Utilization measures, Coordination of Benefits Agreement (COBA) data, and information that is readily available from an MLTSS plan's comprehensive assessment, claims, or encounter data.

Domain 3: Integration Risk Factors							
Indicator	**1. Falls with or without injury**	**2. Wounds new or worsened**	**3. Urinary Tract Infections**	**4. Flu Vaccination**	**5. Pneumococcal Vaccination**	**6. Adherence to Medication Regimen**	**7. Members with Class Polypharmacy**
Descriptive Information							
Measure Type	Process	Process	Process	Process	Process	Process	Process
Question(s)	Percent of all members experiencing a fall within the last 3 months	Percent of all members with a wound that is either new since the last assessment or has worsened since the last assessment	Percent of all members who report having had a Urinary Tract Infection in the last 3 months	Percent of all members who received a flu shot within the past 12 months	Percent of members who received a pneumococcal vaccination in the past 5 years	Percent of all members who are taking specific types of medications and are adhering to medication regimen	Percent of all members with class polypharmacy
Measure Source(s)	NY, IL, MI, and IA MLTSS contracts, MDS, OASIS, and Stars	New York MLTSS contract, MDS, OASIS, Stars, and Diagnosis Codes M0230 or M0240.	New York MLTSS contract, MDS, OASIS	HEDIS	HEDIS	HEDIS-based	
Tier	3	3	3	1B	1B	1B	3

Domain #4: Person-Centered Planning and Coordination

A decade ago, the coordination of medical, mental health, medications, social services, and LTSS was often the equivalent of a full-time job for many people with disabilities and their families. One of the main benefits of enrolling in an MLTSS plan is having the opportunity to interact with a care manager who can guide members through the complex and often fragmented LTSS systems and help coordinate benefits and services in a way that maintains a member's health, community integration, and independence. In line with the NQF HCBS final report, the metrics under "Person-Centered Planning and Coordination" capture the extent to which MLTSS plans approach assessment, planning, and coordination activities in a way that is focused on the member's goals, needs, preferences, and values. These measures are drawn from four primary sources: Mathematica Quality Measures for CMS Programs Serving Medicare-Medicaid and Medicaid-Only Enrollees (Mathematica), the CMS Consumer Assessment of Healthcare Providers and Systems for home- and community-based services (CAHPS-HCBS)[11], State-defined MLTSS contractual measures, and the Council on Quality and Leadership (CQL)'s Personal Outcome Measures (POMS).

[11] The HCBS CAHPS Survey was developed by the Centers for Medicare & Medicaid Services for voluntary use by state Medicaid programs, including both fee-for-service HCBS programs as well as managed long-term services and supports (MLTSS) programs. See: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html

Domain 4: Person Centered Planning and Coordination Measures							
Indicator	**1. Timely Comprehensive Assessment and Update**	**2. Timely Comprehensive Care Plan and Update**	**3. Care Plan Shared Timely**	**4. Re-Assessment and Care Plan Update After Change in Setting**	**5. Transportation Service Level**	**6. Service Confirmation**	**7. Timeliness of Start of Attendant Services**
Measure Type	Process	Process	Process	Process	Process	Process	Process
Question(s)	Percentage of members who have documentation of a comprehensive assessment within the appropriate time frame (within 90 days of enrollment or annually).	Percent of members who have documentation of a comprehensive LTSS care plan within the appropriate time frame (within 120 days of enrollment or annually).	Percent of members with a care plan for whom all or part of the care plan was transmitted to key LTSS providers and the primary care provider within 30 days of development or update.	Percentage of discharges from inpatient facilities in the measurement year resulting in a re-assessment and care plan update within 30 days of discharge.	Percentage of on-time rides	Percent of members that received the services and supports in the care plan.	Average number of days elapsed before services start, for members authorized to receive attendant services. If available, use EVV data for service start date. If EVV not available, use member self-report or service start date on claim
Measure Source	Mathematica	Mathematica	Mathematica	Mathematica, HI MLTSS	Based on NCI-AD #50, CAHPS HCBS #62	To be developed	To be developed
Tier	1A	1A	3	3	3	2	2

Person Centered Planning and Coordination Measures, Continued				
Indicator	**8. Percentage of members reporting care plan includes things important to them**	**9. Percentage of members reporting they are the deciders of what is in their plan**	**10. Percentage of care plans with services and supports that reflect the member's goals**	**11. Percentage of members saying the help received from their care manager is excellent, very good, or good**
Measure Type	Outcome	Outcome	Outcome	Outcome
Question(s)	In the last 3 months, did your Care Plan include: None of the things that are important to you, some of the things that are important to you, most of the things that are important to you, or all of the things that are important to you?	Were you the one who primarily decided what would be in your care plan? Yes/No	How many care plans include services and/or supports that focus on the member's identified goals?	How would you rate the help you get from your care manager? Would you say… Excellent, Very good, good, fair, poor, don't know, refused, or unclear response?
Measure Source	CAHPS HCBS #56	MN MLTSS Contract	POMs (Council on Leadership and Quality's Personal Outcome Measures Adult Survey), 2015	CAHPS HCBS #54, HI MLTSS contract, and NCI-AD #82
Tier	2	2	2	2

Domain #5: Satisfaction

Satisfaction measures aim to capture the member's holistic view of their experience with an MLTSS plan. These measures should represent key milestones and provisions of services, such as satisfaction with a member's care manager or satisfaction with their LTSS provider. Measures of satisfaction should be standardized across services provided in a state so that all individuals receive the same set of questions, and results can be accurately compared across plans and providers. Interestingly, none of the proposed LTSS quality frameworks, including the CAHPS HCBS, including overall satisfaction measures. The MLTSS Trade Association believes member satisfaction with the MLTSS plan, care manager, and key LTSS providers (attendant, institution, assisted living, adult day care, transportation, and fiscal management agency providers) should be assessed.

Domain 5: Satisfaction Measures								
Indicator	**1. Overall Satisfaction with Health Plan Excellent or Above Average**	**2. Overall Satisfaction with Care Manager Excellent or Above Average**	**3. Overall Satisfaction with Attendant Excellent or Above Average**	**4. Overall Satisfaction with Institutional Provider Excellent or Above Average**	**5. Overall Satisfaction with Assisted Living (ALF) Provider Excellent or Above Average**	**6. Overall Satisfaction with Transportation Provider Excellent or Above Average**	**7. Overall Satisfaction with Adult Day Care Provider Excellent or Above Average**	**8. Overall Satisfaction with Fiscal Management Agency (FMA)**
Descriptive Information								
Measure Type	Outcome	Outcome	Outcome	Outcome	Outcome	Outcome	Outcome	Outcome
Question(s)	Percent of members rating overall satisfaction with health plan at excellent or above average	Percent of members rating overall satisfaction with care manager at excellent or above average	Percent of members rating overall satisfaction with attendant at excellent or above average	Percent of members rating overall satisfaction with institutional provider at excellent or above average	Percent of members rating overall satisfaction with ALF provider at excellent or above average	Percent of members rating overall satisfaction with Transportation provider at excellent or above average	Percent of members rating overall satisfaction with Adult Day provider at excellent or above average	Percent of members rating overall satisfaction with FMA at excellent or above average
Measure Source	CAHPS survey	New Survey Items	New Survey Items	New Survey Items	New Survey Items	New Survey Items	New Survey Items	New Survey Items
Tier	1B	3	3	3	3	3	3	3

Proposed Implementation of the Model LTSS Performance Measurement and Network Adequacy Standards for States

The members of the MLTSS Health Plan Association ranked the quality indicators we are committed to reporting on the basis of the current availability of the data needed to report on these metrics and the time that would be needed to implement reporting. The indicators are ranked into three tiers, as follows:

- Tier 1: Initial reporting – data is available now and reporting could begin within a few months of their adoption.
    - Tier 1A: MLTSS plans could report this data for their entire MLTSS population
    - Tier 1B: MLTSS plans could report this data for their managed Medicaid-only population and for dual eligible (Medicare + Medicaid) members who are also enrolled in their MA or D-SNP plan (for whom they would have the necessary clinical information).
- Tier 2: Later reporting – MLTSS plans have data resources that could provide data for these indicators, but would need to create and produce the measures. Reporting on these indicators would occur in a second wave.
- Tier 3: Latest reporting – MLTSS plans would need to create surveys to collect information for these indicators, or would need to modify the output from existing data resources to create these indicators. Reporting on these measures could occur in a third wave.

Tier 1A: Initial Reporting on entire MLTSS Population

Domain	Indicator	Measure Source
# 2 Transition to Most Integrated Setting	2. Successful Transitions from Long-Stay Institution to Community Setting	Proposed Mathematica measure
	3. Admission to an Institution from the Community	Proposed Mathematica measure
	5. HCBS vs. Institutional Services	DE MLTSS Contract
#4 Person-Centered Planning and Coordination	1. Timely Comprehensive Assessment and Update	Proposed Mathematica measure
	2. Timely Comprehensive Care Plan and Update	Proposed Mathematica measure

Tier 1B: Initial Reporting only on the MLTSS Populations for which the plan also holds the Medical risk.

Domain	Indicator	Measure Source
# 2 Transition to Most Integrated Setting	1. Successful Transitions from Short-Stay Institution to Community Setting	Proposed Mathematica measure
	4. Readmission within 30 days of hospitalization	HEDIS
#3 Integration Risk Factors	4. Flu Vaccination	HEDIS/CAHPS survey
	5. Pneumococcal Vaccination	HEDIS/CAHPS survey
	6. Adherence to Medication Regiment	HEDIS-based
#5 Satisfaction	1. Overall Satisfaction with Health Plan Excellent or Above Average	CAHPS survey

Tier 2: Later Reporting – Will Create and Produce Measures from Available Data

Domain	Indicator	Measure Source
# 1 Quality of Life	1. Percent of members able to see their friends and family when they want, and proportion who are not lonely	NCI-AD #7 and #67
	2. Percent of members able to participate in activities outside of home when and with whom they want	NCI-AD #48
	3. Percent of members who are satisfied with where they live	NCI-AD #2
	4. Percent of members who are able to make decisions about their everyday lives	NCI-AD #47, 59, 60, 41
	5. Percent of members who have a job or volunteer in the community	NCI-AD #53, 55, 57
	6. Percent of members who feel safe and know who to talk to if not	NCI-AD #35, CAHPS HCBS #64
#4 Person-Centered Planning and Coordination	6. Service Confirmation	To be developed
	7. Timeliness of Start of Attendant Services	To be developed
	8. Percentage of members reporting care plan includes things important to them	CAHPS HCBS #56
	9. Percentage of members reporting they are the deciders of what is in their plan	MN MLTSS Contract
	10. Percentage of care plans with services and supports that reflect the member's goals	POMs (Council on Leadership and

Domain	Indicator	Measure Source
		Quality's Personal Outcome Measures Adult Survey), 2015
	11. Percentage of members saying the help they received from their care manager is excellent, very good, or good	CAHPS HCBS #54, HI MLTSS Contract, NCI-AD #82

Tier 3: Latest reporting – will need to create surveys to collect information or modify the output from existing data resources

Domain	Indicator	Measure Source
#3 Integration Risk Factors	1. Falls with or without injury	NY, IL, MI, and IA MLTSS contracts, MD OASIS, and Stars
	2. Wounds new or worsened	New York MLTSS contract, MDS, OASIS, Stars, and Diagnosis Codes M0230 or M0240
	3. Urinary tract infections	New York MLTSS contract, MDS, OASIS
	7. Members with Class Polypharmacy	
#4 Person-Centered Planning and Coordination	3. Care plan shared timely	Proposed Mathematica measure
	4. Reassessment and care plan update after change in setting	Proposed Mathematica measure, HI MLTSS measure
	5. Transportation service level	Based on NCI-AD #50, CAHPS HCBS #62
#5 Satisfaction	2. Overall satisfaction with care manager excellent or above average	New survey item
	3. Overall satisfaction with institutional provider excellent or above average	New survey item
	4. Overall satisfaction with assisted living provider excellent or above average	New survey item
	5. Overall satisfaction with transportation provider excellent or above average	New survey item
	6. Overall satisfaction with adult day care provider excellent or above average	New survey item
	7. Overall satisfaction with fiscal management agency (FMA)	New survey item

Model Network Adequacy Standards for MLTSS

Standards used to assess network adequacy for traditional health care services (for which consumers travel to providers) are typically established for a specified geographic service area and create either: 1) a maximum time and/or distance an individual may be required to travel to reach the nearest in-network provider of a given type of service;[12] and/or 2) a minimum ratio of providers to consumers for a given provider type.[13] However, the nature of the services provided as well as the location in which they are provided in LTSS fundamentally differs from traditional health care settings. A significant number of LTSS services involve a service provider traveling to the LTSS consumer rather than the other way around. In such instances LTSS providers travel to where consumers are located to "provide assistance with activities of daily living (such as eating, bathing, and dressing) and instrumental activities of daily living (such as preparing meals, managing medication, and housekeeping)."[14]

The National MLTSS Association recommends states adopt network adequacy standards for LTSS that are based upon time to placement and that acknowledge and account for differences between urban and rural areas as well as agency-directed and self-directed attendant services.

Time to Placement

The best measure of network adequacy in LTSS settings when providers travel to consumers to deliver services is how long it takes from the time a given service is initially requested by the payer to the time at which the service is initially delivered to the consumer at the consumer's location, which is commonly referred to as the consumer's placement. By placing the focus on time to placement payers will be free to build networks designed to provide prompt access to high quality LTSS services.

Separate Network Adequacy Standards for Urban and Rural Areas

States should devise network adequacy standards that acknowledge and account for the differences between urban and rural areas. Physician supply varies dramatically by region of the country, and rural and underserved areas in particular frequently offer little to no basic medical services, as well as advanced specialty or sub-specialty services.[15] As a result, many states have developed separate network

[12] *See, e.g.*., Minn. Stat. Ann. §62D.124 ("Within a health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider...")

[13] E.g., CY2016 MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance, p.2 ("CMS has established ratios of providers required per 1,000 beneficiaries for the specialty types in the MA Provider Table and also for the Facility specialty "Acute Inpatient Hospital" (# of required beds).")Web. https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2016_MA_HSD_Network_Criteria_Guidance.pdf

[14] Reaves, Erica L., and Musemeci, Mary Beth. *Medicaid and Long-Term Services and Supports: A Primer*. The Henry J. Kaiser Family Foundation, 15 Dec. 2015. Web. http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/

[15] Supply-Sensitive Care, *The Dartmouth Atlas of Health Care*. Web. http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2937

adequacy standards for urban and rural areas for these types of traditional health care. Potential shortages of LTSS providers in rural areas demand a similar approach.[16] States should develop separate network adequacy standards for rural areas that are less stringent than those in urban areas, which will allow payers to build networks designed to provide reasonably prompt access to high quality LTSS services.

Separate Network Adequacy Standards for Agency and Self-Directed Attendant Services

States should devise distinct network adequacy standards that acknowledge and account for the differences between agency-directed and self-directed attendant services. Self-direction "shift[s] control over resources and staffing" from service providers to consumers, allowing consumers "to determine the role that the provider will play in his or her life."[17] Increasing consumer control in this manner presents many benefits but may also create some challenges for network adequacy standards crafted for agency-directed models because consumers may choose providers who may be farther away or may be unable to visit the consumer frequently. States that offer consumer-directed options must devise distinct network adequacy standards for self-directed attendant services that recognize and account for the various differences between these two models.

One potential source of network adequacy standards for self-directed attendant services are the measures recommended in the *Workforce* domain of the September 2016 NQF report on *Quality in Home and Community-Based Services to Support Community Living.* The measures in this domain specifically assess the level to which:

1. "The supply of and the demand for the HCBS workforce are aligned in terms of numbers, geographic dispersion, and availability";
2. "The HCBS workforce is provided compensation, benefits, and opportunities for skill development as a means for ensuring a stable supply of qualified workers to meet the service and support needs of HCBS consumers"; and
3. "The workforce is able to deliver services that are aligned with the cultural background, values, and principles of the HCBS consumer (i.e., cultural competency of the workforce) and the level to which the HCBS system trains and supports the workforce in a manner that is aligned with the cultural background values, and principles of the HCBS workforce (i.e., cultural competency of the

[16] Woodcock, Cynthia H. *Long-Term Services and Supports: Challenges and Opportunities for States in Difficult Budget* Times. Rep. National Governors Association. Web. http://www.hilltopinstitute.org/publications/ltSSChallengesandopportunitiesforStatesindifficultBudgettimes-December2011.pdf; ("The availability of LTSS providers and robust provider networks, particularly in rural and frontier areas, is a major concern for states looking to expand their HCBS programs.")

[17] The Case for Medicaid Self-Direction: A White Paper on Research, Practice, and Policy Opportunities, *National Council on Disabilities*. Web. http://www.ncd.gov/publications/2013/05222013A/05222013ACh1

HCBS system)." [18]

The NQF recommended measures include:

Subdomain: Sufficient workforce numbers, dispersion, and availability	Source
Percent responding no to: Is it difficult for you to find attendant providers for your care?	EAZI
Percent responding "not very hard" to: How hard was it, overall, for you to find someone to help that you were satisfied with?	C&C9MO
Number of home health and personal care aides per 1000 people with self-care and independent living disabilities.	LTSS Scorecard
Subdomain: Adequately compensated, with benefits	**Source**
No measure concepts	
Subdomain: Culturally competent	**Source**
Percent responding yes to: My worker is sensitive and responsive to customs and traditions of my culture or background.	MAHCSS
Percent responding yes to: Are services delivered in a way that is respectful of your family's culture?	NCI-AFS, NCI-FGS
Percent responding yes to: Do you communicate with your attendant provider in the language that you prefer?	EAZI

Since no measures currently exist to assess whether the self-directed attendant workforce is adequately compensated with benefits, the National MLTSS Association recommends CMS do a pre/post study in a geography that has undergone the switch to a higher wage. Alternatively, CMS could identify geographies that are similar and run a controlled experiment.

Engage Consumers to Assess Network Adequacy

States should solicit feedback from consumers of self-directed attendant services to assist in assessing network adequacy. Consumers should have an opportunity to say whether they received attendant services: 1.) at the appropriate level; 2.) in the appropriate amount; 3.) at the appropriate time; and 4.) in the appropriate place. By soliciting this information from consumers, states can better ensure that the fundamental purpose of network adequacy standards is being fulfilled. States should rely upon either the consumer's MLTSS plan or the Fiscal Management Service, depending on how the state has structured the MLTSS program, to survey consumers for this information since they are already in communication with the consumer.

[18] NQF, p. 26.

Conclusion

The model LTSS performance measures and network adequacy standards in this paper were developed by the member companies in the National MLTSS Health Plan Association in an effort to hold ourselves accountable to the people we serve and to assist States in complying with the July 1, 2017 and 2018 regulatory deadlines. We look forward to engaging with public officials, states, our members, their families, advocates, and the community-at-large to contribute to the larger policy dialogues around standardized, comprehensive approaches to MLTSS performance and network adequacy and offer our Association as a resource in that regard.