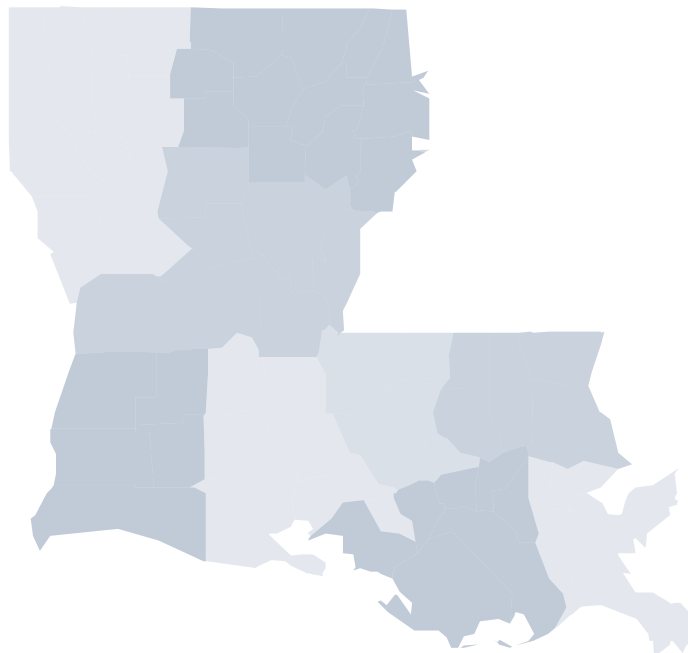




DEPARTMENT OF HEALTH
AND HOSPITALS

TRANSFORMING LOUISIANA'S LONG TERM CARE SUPPORTS AND SERVICES SYSTEM

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Initial Program Concept



AUGUST 30, 2013

Our Vision

Introduction

Over the past decade, the Department of Health and Hospitals (DHH) has engaged stakeholders in a comprehensive effort to reform Long Term Support and Services (LTSS) by right-balancing services between institutional and community settings and improving quality, expanding service options, and addressing financial sustainability. These efforts produced the 2006 *Plan for Immediate Action* and *Louisiana's Plan for Choice for Long Term Care*, developed and largely implemented over the past several years. While these efforts have achieved positive results in lowering per-person costs, increasing the number of persons receiving services in the community and avoiding unnecessary institutionalization, evolution of new delivery models, the growing demand for services and the ongoing fiscal reality call for a new approach to providing long term care.

In addition, the Department has worked carefully to develop a transformation of Louisiana's Medicaid and behavioral health systems through the introduction of comprehensive coordinated care strategies. These strategies integrate service planning, delivery and management to provide better access, consumer satisfaction, quality and efficiency. Our top priority throughout the development and implementation of the Bayou Health and the Louisiana Behavioral Health Partnership (LBHP) Medicaid managed care models has been improving health outcomes for our recipients. Both of these programs follow an integrated care model and include a stronger focus on coordination of care than was possible in our legacy systems.

In 2006, DHH successfully implemented a small scale managed care model through the

operation of two PACE (Program for All-Inclusive Care of the Elderly) programs. Now, Louisiana is ready to move forward with its next phase of delivering coordinated care through the creation of a new managed long-term care program to better organize and integrate the delivery of Medicaid services to individuals receiving Medicaid-funded LTSS.

On November 29, 2012, DHH issued a Request for Information (RFI) seeking creative, innovative and viable strategies that would assist the state with this effort. In that request, DHH identified five key objectives, which continue to guide our reform efforts:

1. Improve quality of services and health outcomes;
2. Decrease fragmentation and improve coordination of care;
3. Create a system that utilizes proven and/or promising practices;
4. Refocus the system in order to increase choice and provide more robust living options for those who need LTSS and their families; and
5. Rebalance the system in order to meet the growing demand for services within the existing level of expenditures for the LTSS population.

What follows serves as an initial concept of the foundation of the LTSS transformation. The discussion outlines key elements to be resolved in pursuit of the transformation. DHH is seeking stakeholder feedback on this concept, as involvement from those who access, provide and advocate for those who receive long term care is critical to this transformation.

An Ongoing Transformation

Long Term Care in Louisiana has traditionally been largely institutionally based, regardless of the population served. By the early 1990s Louisiana was among the states with the highest number of nursing homes and nursing home residents per capita. The state began the process of “rebalancing” relatively late compared to other states, but has made considerable progress since 2000 when Louisiana ranked 49th in percentage of spending for community-based vs. institutional long-term care for the elderly and people with disabilities. By 2009, Louisiana’s rank had risen to 14th – a significant accomplishment (Thomson Reuters, *Medicaid Long Term Care Expenditures, 1996-2009*). But clearly we can do better, and there continues to be a need to focus on right-balancing the system to better meet the needs of those accessing services while also reducing costs.

In terms of people with developmental disabilities, Louisiana has made considerable progress over the past fifteen years. Between fiscal years 2000 and 2010, the percent of spending for institutional services for people with disabilities has improved from 78% to 53%, while spending in the community has risen from 22% to 47%. However, Louisiana still ranks 3rd nationally in ICF/DD residential facility utilization (Braddock, D. *State of the States in Developmental Disabilities 2013 edition* (data from 2011)). Our improvements have largely been tied to reducing public institutional reliance. Since 2007, eight supports and services centers have closed or have been moved to private management through cooperative agreements, leaving one state operated large institution. Despite these reductions, the number of persons served in private ICF/DD community and group homes has remained steady. The average occupancy rate of private ICFs/DD is consistently more than 90%, with the service being the only readily available supports option. Despite the addition of 2,175 waiver slots since 2008, there is still additional need for community service capacity. Some individuals in crisis continue to be admitted to Louisiana’s remaining large public supports and services center, and by better managing our service delivery system we can serve

more individuals in the community with our current resources.

National and state trends indicate an increasing demand for home and community-based services (HCBS) based on both demographics (aging of society in general and increased longevity of people with developmental disabilities) and legal forces (*Olmstead* lawsuits). Currently, Louisiana spends about 44% percent of its Medicaid long-term care funding for older adults and people with adult onset and developmental disabilities on home and community-based services (HCBS), while 55% percent of funding is spent on institutional services. Breaking out the spending differences by population reveals that LTSS spending for aging adults are more slanted toward institutions than people with developmental disabilities (31% community to 69% institutional for aging populations and 59% community to 41% institutional for people with developmental disabilities).

The Case for Managed Long-Term Supports and Services

Comprehensive managed care for long-term supports and services offers a significant opportunity to create a more equitable and sustainable system of care. There has been a growing movement in this direction across the nation, from eight states in 2004 to 13 in 2013 with managed LTSS programs. CMS has recognized these intensifying interests by providing further guidance on the issue to states recently. However, given the complex needs and vulnerabilities of persons served, as well as the need to extend the focus of care management from a typical medical model to a more holistic approach, DHH recognizes the need for a thoughtful and carefully balanced approach to pursuit of managed LTSS. Louisiana is focused first on developing the necessary framework to comprehensively manage the growing needs of this Medicaid population.

Ultimately, DHH believes that a comprehensive managed LTSS program can improve the quality of life for many our state’s most vulnerable residents. By providing more integrated services, the experience of navigating the health care and supports systems will be simplified. Through better

program design and incentive alignment, we can make significant progress toward our goals of rebalancing the service system. States that have successfully implemented managed LTSS report progress on rebalancing, developing alternative services, and building networks that support the delivery of high-quality and effective LTSS in both facility and home and community-based settings.

Providing an integrated delivery model will ensure that individuals receive the most appropriate level of care at the right time and location, with the goal of reducing unnecessary hospitalization and emergency department utilization. The integrated delivery model will also better facilitate planning and connections between in-home personal care services, medical services, behavioral health services and frameworks to facilitate provision of natural (i.e., family members) and community supports. Managed LTSS introduces important cost controls that limit the state's risk and provides for improved budget predictability for one of the largest growing shares of the state's budget outlay, providing a mechanism for Louisiana to balance resources and reinvest savings in a stronger community-based system that can help address unmet needs.

A Collaborative Process

DHH recognizes that success in designing and implementing MLTSS will be largely dependent on the engagement of stakeholders throughout the process. The Department is committed to the active inclusion of cross-disability groups, as well as community, provider and other advocacy representatives in order to provide comprehensive and meaningful input to both the planning and operation of this program.

DHH is publishing this concept paper as a catalyst for public comment and discussion. Materials and communications related to long-term care reform will be continually posted to MakingMedicaidBetter.com. There, individuals and groups will also be able to submit feedback directly to DHH and sign up to remain informed as the program proceeds. Additionally, questions, comments and other feedback can be submitted by email to LongTermCare@la.gov.

In an effort to formalize channels for feedback, DHH will also be establishing an

advisory group that will meet continuously through this process to provide active guidance to the Department. Members of the group will be appointed by the DHH Secretary and will include representation from potential program participants, including those individuals with disabilities, as well as community, provider, policy maker and advocacy groups.

DHH also will hold public forums in different regions of the state to present the tenets this reform and engage in a meaningful dialogue to answer questions and accept public comment. Format, content and schedule of these forums can be constructed with guidance from the advisory group. Once determined, the schedule of forums will be available on MakingMedicaidBetter.com. Material from the forums, including video from at least one forum and answers to frequently encountered questions, will also be posted online.

Louisiana's Approach

DHH has kept abreast of the growth in managed LTSS (MLTSS) and has and will continue to research best practices and lessons learned from successful MLTSS implementations and programs in other states. These observations will be incorporated into Louisiana's MLTSS program design, along with recent Center for Medicare and Medicaid Services (CMS) guidance related to MLTSS. All of these observations, along with lessons learned from the development and ongoing operation of Bayou Health and the LBHP, contribute to the framework described in this concept paper.

This concept paper only provides the initial framework. DHH is seeking feedback from stakeholders related to many of these topics. Specific areas where the Department is actively soliciting guidance are noted.

INCORPORATING CMS KEY PRINCIPLES

Louisiana's approach will incorporate the ten key principles identified by CMS in May 2013 guidance as being inherent in strong managed LTSS programs. These principles were developed and issued by CMS in recognition of the shift in delivery system

design and its desire to maximize the positive experience of Medicaid recipients as they make the transition to more integrated service models. The principles are:

1. Adequate Planning and Transition Strategies
2. Stakeholder Engagement
3. Enhanced Provision of Home and Community Based Services
4. Alignment of Payment Structures with MLTSS Programmatic Goals
5. Support for Medicaid Beneficiaries
6. Person-Centered Processes
7. Comprehensive and Integrated Service Package
8. Qualified Providers
9. Participant Protections
10. Quality

DHH seeks feedback from stakeholders on how these principles can most effectively be incorporated into the MLTSS program design.

Stakeholders can view the above-mentioned federal guidance as well as other MLTSS support materials from CMS at [Medicaid.gov](https://www.medicare.gov), or by clicking [here](#).

POPULATIONS

A system that coordinates care for individuals who are receiving long-term care supports and services, while also helping to identify and manage those who are or could become at-risk for receiving such services, provides the greatest opportunity for rebalancing.

Medicaid and Medicare Eligibles

Many individuals in Louisiana are dually eligible for Medicaid and Medicare benefits and are receiving services through various DHH programs. DHH believes it is important for these individuals to be included in the managed LTSS program design and intends to include both dually-eligible recipients of LTSS as well as recipients covered only by Medicaid.

People with Developmental Disabilities

Persons with developmental disabilities have historically not been included in managed long-term care programs, as these programs have focused primarily on medical supports. A growing number of states are operating pilot programs or planning transitions to a model that is more inclusive of those with developmental disabilities. The MLTSS program proposed for Louisiana will extend to all areas of life, ranging from in-home services to employment supports. Thus, we believe that persons with developmental disabilities will benefit greatly from comprehensive coordination of care to decrease fragmented delivery of care across physician, behavioral and waiver services.

While Louisiana intends to pursue inclusion of both the elderly and those individuals with developmental disabilities or other special needs, the state seeks feedback from stakeholders about the best approach for this policy. Such decisions under consideration include:

- **Should all populations be transitioned to MLTSS at the same time? If no, what interval would be optimal?**
- **Should the Department pursue a single procurement for entities to provide services to individuals with both physical disabilities/frail elders and individuals with developmental disabilities or, recognizing that entities have varying levels of experience with the two populations, pursue two separate procurements?**

ENROLLMENT

Louisiana believes broad inclusion with mandatory enrollment provides the framework to make significant improvements in both quality and cost. Robust outreach and education to assist people in choosing plans and providers are essential, and the use of a neutral enrollment broker, with a strong emphasis on consumer choice, is an essential part of any implementation. DHH likewise believes selection is the right of the individual enrollee and not of

the managed care organizations (MCOs) that will coordinate services. Thus, participating MCOs will be mandated to accept any and all enrollees who select them.

While the Department believes that broad inclusion and mandatory enrollment provide the strongest program foundation, DHH seeks input regarding how individual populations can best be served through this framework and what factors should be taken into consideration for effective planning outreach and enrollment activities.

BENEFIT DESIGN

When designing a benefit package that will be managed by an MCO, a state may decide to exclude, or “carve-out,” specific sets of services and continue to deliver those through the legacy fee-for-service program or through a separate managing entity. Currently, Bayou Health includes carve-outs for dental, specialized behavioral health, individuals receiving hospice services, targeted case management, personal care services, individuals receiving nursing facility and waiver services and individual education plan (IEP) services billed through school districts. Specialized behavioral health needs are provided through the Louisiana Behavioral Health Partnership, which is currently managed by Magellan Health Services.

Both the responses to our RFI and follow-up presentations made to DHH staff provided a consistent suggestion that benefits coordinated through the MLTSS MCO should be comprehensive and avoid carve-outs, particularly as it related to behavioral health. In fact, recent guidance from CMS suggests that MCOs should provide or coordinate *all* acute and primary care, pharmacy, behavioral health services (including those services necessary to address behavioral issues associated with other health conditions) and LTSS (including both institutional and non-institutional care). Respondents cited high levels of comorbidities among the LTSS population that can be more effectively managed through an integrated approach. MCOs also provided examples of successful experience of analytic

capabilities available when the plan has access to data from providers across the clinical spectrum. Generally, DHH believes that carve-outs maintain fragmentation and care is best rendered when coordinated by one entity.

In order to develop an integrated and effective benefit package of coordinated services that best meets the needs of those receiving long-term care supports and services, DHH seeks feedback from stakeholders about which services should be included within the scope of the MLTSS MCO.

COORDINATION WITH MEDICARE

CMS recently began to consider allowing states to develop fully integrated programs that combine Medicaid and Medicare on a large scale, such as the Program for All-Inclusive Care for the Elderly (PACE) does on a small scale. CMS has further allowed states to share in some Medicare savings. This option is still very new and presents additional difficulties in coordinating rules and procedures between the two payer sources. For these reasons, DHH is not committing to a fully integrated approach at this time.

Nevertheless, coordination with Medicare is important for dual eligibles to attain good health outcomes, for the state to ensure Medicaid is the payer of last resort and for providers to ensure appropriate reimbursement.

DHH seeks feedback from stakeholders on how to coordinate services with Medicare.

FOCUS ON REBALANCING

All MLTSS programs must comply with the Americans with Disabilities Act (ADA) and the Supreme Court's *Olmstead v. L.C.* decision. Services provided through the MCO are required by law to be delivered in the most integrated fashion and setting, maximizing opportunities for the individual to live actively in the community. Managed LTSS in other states is being successfully coordinated with initiatives like Money Follows the Person (MFP) and the Balancing Incentive Program (BIP) to aid in rebalancing. Louisiana is participating in these

initiatives as well, having been awarded a MFP grant and more recently, been approved for BIP in 2013. Together they have great potential for developing a wider array of community-based services and providing an opportunity for providers to diversify.

DHH seeks guidance on how the program can best be designed to support rebalancing efforts in the state, while promoting cost-effectiveness and ensuring that high-quality institutional services remain available to and viable for individuals when such care is needed.

CONSUMER PROTECTIONS

CMS requires that states offer all MLTSS recipients conflict-free education, assistance with enrollment and disenrollment and consumer-friendly education and advocacy. Further safeguards are required to protect participant health and well-being, including a statement of participant rights and responsibilities; a critical incident management system to guard against abuse, neglect and exploitation; and fair hearing rights.

DHH seeks input on innovative and effective strategies to ensure that MLTSS participants receive adequate protections.

PROVIDERS

As enumerated above, best practice dictates that MLTSS provide certain protections and requirements regarding providers that participate in the program. One of the most important is including stringent network adequacy requirements for participating MCOs.

DHH seeks input regarding long-term care-specific network adequacy requirements, as well as guidance on how to ensure the transition from fee-for-service (FFS) to MLTSS makes effective use of the existing provider network to the best extent possible. DHH also seeks input on effective means to support traditional LTSS providers and help them prepare for the transition through technical assistance or other means.

CHOOSING OUR PARTNERS

DHH will choose its partners for MLTSS through a competitive procurement process,

beginning with a public release of a Request for Proposals (RFP). While the final RFP will detail how responses will be scored for purposes of award, DHH intends to place significant value of respondents' previous experience with long-term care populations and services, including their ability to build networks, provide proven clinical tools and engage with stakeholders and advocacy groups and consumers specific to this population.

DHH seeks input regarding RFP contents and requirements for a strong program framework that promotes improved health outcomes, better coordination of care and a more effective and efficient delivery system.

CARE COORDINATION

A primary objective of the program will be ensuring that members, when appropriate, have a designated and meaningful medical home that is supported through an interdisciplinary care team and an individualized, plan of care that supports patient choice and self-direction. There will be significant emphasis on care management strategies, particularly with regard to chronic conditions and managing dual behavioral and physical needs.

DHH seeks suggestions for innovative approaches to achieve an optimal level of care coordination through its RFP and seeks feedback regarding important design elements or considerations that should be included.

MEASURING QUALITY AND OUTCOMES

CMS guidance related to MLTSS provides high expectations regarding quality of care and reporting requirements. DHH intends to require plans to develop comprehensive and transparent quality strategies tailored to the needs of this population, which also must be guided by and integrated with both existing and future state-driven priorities.

DHH seeks feedback regarding quality requirements for MCOs, as well as feedback to ensure the process provides for initial and ongoing stakeholder input.

DHH also intends to place a strong emphasis on public reporting. Contracts with MCOs will require ongoing reporting of HEDIS, CAHPS and state-determined LTSS measures specific to these services and population.

DHH seeks input on which specific measures should be included in these requirements and how they can most effectively be reported and used to shape the program.

ACCOUNTABILITY

DHH intends to develop and include strict accountability standards for our chosen MCO partners. In the development of the Medicaid managed care model, Bayou Health, DHH observed many lessons learned from other states, including the need for the ability to both financially sanction and award plans for their performance. Based on feedback from stakeholders, this also included the requirements for an 85 percent medical loss ratio (MLR), where at least 85 percent of our premiums paid to the plan were spent on qualifying health services. DHH believes MCO rate methodology should be designed to support the Department’s goals, ensuring adequate compensation for all providers, improving access, incentivizing quality and providing the state with increased budget predictability.

In conjunction with the quality and reporting requirements, DHH seeks feedback

on effective contractual and rate methodology strategies that promote high performance from our partners. This could include financial penalties and awards for performance, how to tie these to outcomes in a way that promotes the program’s goals and mission, and other tools that ensure adequate accountability from the MCO.

IMPLEMENTATION

DHH recognizes the importance of providing adequate time to plan, design and launch an LTSS program. The process must provide sufficient opportunity for public review and engagement, while also protecting fragile populations during transition.

This concept paper represents a first step in the discussion of how Louisiana can strengthen the long-term care supports and services system. As highlighted, there are still many important steps ahead of as we gather feedback and finalize our pathway to improve the model of delivering long-term care. Some of these steps are broadly outlined in the below table.

DHH seeks input on the implementation timeline, as well as suggestions regarding how the program can most effectively be brought online. Specifically, the Department seeks input regarding geographic, service-driven and population-specific phase-ins.

Transforming Louisiana’s Long Term Care Supports and Services System

*For additional information, please visit
MakingMedicaidBetter.com/LongTermCare*

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