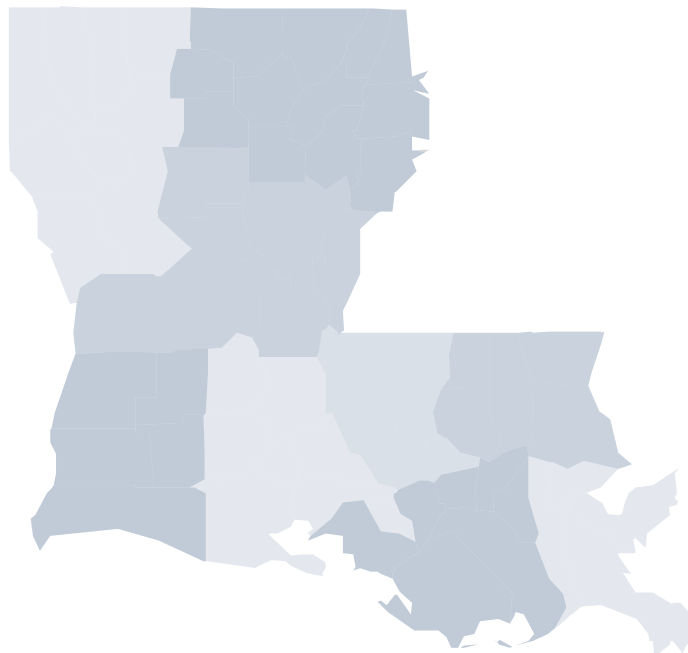




UPDATE ON THE DEVELOPMENT OF MANAGED LONG-TERM SUPPORTS AND SERVICES IN LOUISIANA



APRIL 2014

Long Term Supports and Services Transformation Framework:

Executive Summary

The intent of this document is to update the Centers for Medicare and Medicaid Services (CMS) on the transformation of Long-Term Supports and Services (LTSS) in Louisiana. The Louisiana Department of Health and Hospitals (DHH) is preparing to seek CMS approval to move its long-term supports and services system to a managed-care model. A managed care model would improve overall health outcomes and quality of life through the coordination of care, address barriers inherent in ongoing efforts to rebalance services and supports, and would establish financial predictability and sustainability for the Medicaid program. To goal of moving to a system of managed care would be to ensure the continuity of services for vulnerable persons served in the LTSS program.

This paper outlines the State's initial vision, made in consultation with CMS-contracted experts, other states, advocates for LTSS populations, providers, and other stakeholders. The LTSS design explained in this paper is only preliminary in nature. Final decisions have not yet been made. The State looks forward to continuing working with stakeholders and its federal partners in the ongoing development of a plan for comprehensive transformation of long-term supports and services.

Background. Over the past decade, DHH has engaged stakeholders in an effort to reform LTSS by right balancing services between institutional and community settings. It has also sought to improve quality, expand service options and addressing financial sustainability within the existing LTSS system. These efforts produced the 2006 Plan for Immediate Action and the 2007 Louisiana's Plan for Choice for Long-Term Care, developed and largely implemented over the past several years. In addition, DHH is currently participating in the Money Follows the Person Rebalancing Demonstration (MFP) and Balancing Incentive Payment (BIP) Program. These initiatives consistently demonstrated productive

department-wide collaboration, with commitments from Medicaid (the Bureau of Health Services Financing), the Office of Aging and Adult Services (OAAS), the Office for Citizens with Developmental Disabilities (OCDD), and the Office of Behavioral Health (OBH), as well as partnerships with other state and local affiliates. The transformative efforts of DHH have not shied from innovation, with the State designing a nationally recognized permanent supportive housing program and including in the MFP innovative supplemental/demonstration supports to address family caregivers and dual diagnosis. DHH has a history of approaching systems barriers with creativity and a focus on achieving sustainable outcomes.

Since 2008, DHH has successfully implemented a small scale managed-LTSS model through the operation of two PACE (Program for All-Inclusive Care of the Elderly) programs. Over the past several years, DHH 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. DHH's top priority throughout the development and implementation of the Bayou Health (Medicaid) 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 Louisiana's legacy systems. The successes of these programs demonstrate the benefits of coordinated care strategies, the positive outcomes of which DHH believes can and should be transferred to the persons served in LTSS. The State believes that DHH's strong foundation of collaboration and stakeholder involvement, experience in implementation of managed- care reform, and experience in transformative improvements in LTSS will assure ensure that this effort is successful.

The MLTSS Plan. Comprehensive managed care for LTSS 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 MLTSS programs. 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 MLTSS.

Ultimately, DHH believes that a comprehensive MLTSS program can improve the quality of life for many of 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 continue to 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 facilities, 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. Targeted network development and comprehensive coordinated care will help achieve this objective and improve individual outcomes. 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 meaningful community integration, including employment and sustainability of natural and community supports. DHH has consistently communicated with stakeholders that MLTSS is not viewed as a cost-reduction mechanism, but instead it is viewed by DHH as an opportunity to serve more persons in a sustainable manner. Any savings realized as a result of the implementation of MLTSS would be re-invested in providing additional supports and services.

Progress on MLTSS in Louisiana

DHH has kept abreast of the growth in MLTSS and has and will continue to research best practices and lessons learned from successful MLTSS implementations and programs in other states. On November 29, 2012, DHH issued a Request for Information (RFI) asking for "creative, innovative and viable strategies that will assist Louisiana with restructuring the organization and delivery of Medicaid services to individuals receiving Medicaid-funded Long-Term Services and Supports (LTSS)." Respondents were encouraged to "propose efficient managed care delivery options for providing comprehensive, quality care in a cost-effective and sustainable manner, including recommending the populations and types of services for inclusion in the proposed delivery model(s)." DHH received eighteen responses to the RFI. Building upon the RFI responses, in the August of 2013, DHH issued an initial concept paper for the transformation of LTSS in Louisiana.

Following the release of the initial concept paper outlining Louisiana's intent to transform LTSS, DHH began a robust effort of involving stakeholders across the state. In October 2013, DHH convened an advisory group of stakeholders (the MLTSS Advisory Group) to discuss basic program design and how best to meet people's needs through MLTSS. This is a diverse group of stakeholders representing providers, families and advocates.¹ Within the standing MLTSS advisory group, smaller focused work groups were formed to research and form recommendations to address key design elements for MLTSS. These stakeholders discussed research and information available from other states. DHH created concept briefs that provided background on these areas, and each group presented its recommendations to the entire MLTSS advisory group and department staff at the close of each MLTSS advisory meeting. These areas were:

- ▶ Accountability
- ▶ Consumer Protections
- ▶ Measuring Quality and Outcomes
- ▶ RFP Development and Procurement

See Appendix A.

- ▶ Stakeholder Engagement and Communications
- ▶ Benefit Design
- ▶ Care Coordination
- ▶ Enrollment
- ▶ Populations

MLTSS advisory group recommendations are reflected in this document and will be applied directly to the development of the MLTSS system of care.

Public outreach and comment will continue to be sought by DHH. All publications, support materials, schedules and meeting minutes are posted at the dedicated MLTSS website, www.MakingMedicaidBetter.com/LongTermCare. Beginning in late February 2014, there were a series of webinars and public meeting seeking the input and comments of other interested parties. These comments will also be used to further develop the MLTSS proposal. By June 2014, a draft concept paper will be presented to the MLTSS advisory group and will be submitted to CMS. The concept paper will reflect guidance from CMS, the RFI responses and from stakeholders from across the state.

Preliminary Design Considerations

The following considerations are the results of the State's steady and deliberate MLTSS planning and development process. These positions are subject to refinement as the State continues actively involving stakeholders and experts in formulating the final system approach.

Waiver Authority. The State of Louisiana and stakeholders engaged through the MLTSS advisory group generally favor pursuit of a Medicaid Section 1115 Research and Demonstration Waiver as the authority for the systems transformation at this time. The State intends to incorporate system improvements, such as additions in services and strategies that integrate more effective lifespan transitions, support rebalancing, support flexibility and self-direction, facility diversion, and transition. Other innovative components can be included in the 1115 application, such as a tiered rate structure.

MLTSS operated under an 1115 introduces opportunity for fiscal strategies that may support additional availability of home and community-

based services through utilization management, reinvestment and efficiencies, as well as provision of non-typical or innovative, supports that may reduce overall reliance on paid services over time. The State envisions the 1115 waiver taking the place of the 1915c waivers for all populations and will incorporate proposals for transitioning these persons and services to the 1115 structure leading to a greater ease in administration. The waiver will allow Louisiana to organize its health care system in a manner that takes advantage of all resources at every level to promote better health outcomes for the residents of Louisiana.

Procurement. DHH recognizes that there are both similarities and differences in the systems of care supporting persons with age-related and adult-onset disabilities and persons with developmental disabilities. In the implementation of MLTSS, DHH is committed to creating a system of care that works best for the populations served. To best address the differences in populations covered by LTSS, the State intends to pursue two procurements, one for the populations covered by OAAS and one for the populations covered by OCDD. It will also allow a careful phase-in of persons with developmental disabilities. DHH has maintained an online archive of the procurement processes for both Bayou Health and LBHP, and intends to continue this with the MLTSS procurement process.

Populations. Louisiana's existing Medicaid managed-care program, Bayou Health, has carved out some LTSS populations, specifically:

- ▶ People eligible for both Medicaid and Medicare (dual eligible);
- ▶ People with developmental disabilities who are receiving care at an intermediate care facility for the developmentally disabled (ICF/DD) or HCBS waiver services;
- ▶ People with adult-onset and age-related disabilities who are receiving nursing home or HCBS waiver services; and
- ▶ Chisholm class members defined as all current and future recipients of Medicaid in Louisiana under age 21 who are now or will in the future be placed on the OCDDs' Request for Services Registry.

The State supports including all of these populations in the MLTSS system. DHH will carefully

consider the impacts of the population composition on both the efficacy and effectiveness of the MLTSS design. The MTSS advisory group and the State recommend that PACE should remain an MLTSS option in the areas where it currently operates.

The initial MLTSS plan will not impact services provided under Medicare for dual-eligible participants. The State's plan for moving long-term supports and services into managed care does not currently include integration of Medicare and Medicaid. Services covered and paid for by Medicare will continue to be paid for by Medicare. Services covered and paid for by Medicaid will continue to be paid for by Medicaid. Those entities that manage the care of Medicare enrollees will continue to manage those Medicare services. MLTSS entities will only manage the benefits provided and paid for under Medicaid. The Department's policy is that no dual-eligible member will be moved from an existing Medicare Advantage (MA) Plan or precluded from enrolling in a MA Plan. Further, the Department would discourage steerage into any particular plan available. DHH is committed to the participant's right to choice.

Persons with Developmental Disabilities

Persons with developmental disabilities have historically not been as widely included in MLTSS programs for a variety of reasons. A growing number of states are operating pilot programs or planning transitions to models that are more inclusive of those with developmental disabilities. The MLTSS program proposed for Louisiana will extend to all areas of life, including in-home services to employment supports. DHH believes 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.

There is no anticipation that there will be any change in categorical eligibility. Eligibility for developmental disabilities is defined by state law and will not change with the implementation of MLTSS. The implementation of MLTSS through an 1115 waiver could potentially address the sustainability of the state's widely supported early intervention program serving at-risk children from birth through the age of three. By expanding

coverage to persons not otherwise Medicaid-eligible, a seamless system for care throughout an individual's life would be developed.

Enrollment. DHH and the MLTSS advisory group generally support mandatory enrollment of all populations, with strong safeguards for individuals. Broad inclusion with mandatory enrollment provides the strongest program framework to make significant improvements in both quality and cost. Mandatory programs not only guarantee higher enrollment, they also make it more possible for MLTSS contractors to build a strong network. This is a particular concern given that the populations impacted by MLTSS are much smaller than in DHH's previous experiences with managed care. Maximum program participation at onset for both groups is less than 100,000 people. A strong network means that services are accessible and available to people when and where they are needed. Mandatory enrollment also better supports DHH's goals to hold managed-care organizations (MCOs) accountable for improving health and quality-of-life outcomes in addition to providing better budget predictability.

Robust outreach and education to assist individuals and caregivers in choosing plans and providers are essential. The use of a neutral enrollment broker, with a strong emphasis on consumer choice, should be an essential part of this implementation. MLTSS will provide an opportunity to address fragmentation in contact points, as well as to improve the information available to persons seeking LTSS. The State is planning to incorporate MLTSS into the BIP plan and will look for opportunities to streamline the no-wrong-door-system for all LTSS recipients. Both the MLTSS advisory group and DHH strongly believe that there must be effective enrollment counseling in the proposed MLTSS transformation.

Continuity and Fullness of Life. Continuity of care and fullness of life are important to persons with multiple and complex disabilities. DHH notes that in other states implementing or planning a shift to MLTSS, families and service recipients frequently experience anxiety related to uncertainty of benefits change. DHH feels strongly that initial enrollment should allow members to retain their current providers whenever practicable. The MLTSS advisory group recommends a period of transition for consumers and providers with

basic assurances in place for addressing continuation of necessary services and related payment as plans of care are updated. Continuity provisions will seek to make the MLTSS implementation process transparent and understandable.

General practices suggest that the MLTSS transformation will have policies that support allowing persons to change plans at initial and annual enrollment, and would provide members 45 days post-enrollment to change plans without needing to show cause. Policies will be put in place to align families in the same plans and to allow change if the plan cannot meet an individual's current needs. The State and stakeholders have a strong investment in ensuring persons remain in community settings, and thus plan changes may be offered if an alternate plan may support a person to remain in the community rather than to admit the individual to an institution.

DHH believes selection is the right of the individual enrollee and not of the MCOs that will coordinate services. Thus, DHH proposes that participating MCOs will be required to accept any and all enrollees who select them. Prior to rollout, there will be a readiness assessment to guarantee network adequacy; this assessment will be designed based upon best-practice recommendations.

Benefit Design: The MLTSS approach proposed by Louisiana will include full integration of LTSS with primary, acute and behavioral health services; care coordination will be a key integrating mechanism at the individual level and an important administrative control. Benefit design will include both HCBS and institutional services. State plan acute, pharmacy, long-term personal care services and Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program will be included in the MLTSS systems transformation.

Plans will be empowered to provide a wide array of services that enhance the ability to support individuals in community-based settings. Plans of care will be comprehensive, individualized, person-centered and responsive to changing needs and goals. MLTSS will provide opportunities to manage and coordinate care across settings, and to facilitate both institutional diversion and transition.

Rebalancing. DHH will specify maintenance-of-effort requirements consistent with CMS initiatives

MFP and the BIP. DHH believes plan participation in the goals of MFP and BIP, as well as CMS maintenance of effort requirements, will be explicit in the RFP; plans should be asked to describe their approach along with any evidence of effectiveness. Given that Louisiana has differences in the relative costs of community versus facility care between the two major populations receiving LTSS, the two procurements may require different rate structures and types of incentives. For example, a blended rate might work well for persons with age-related and adult-onset disabilities, but the rate might have to be adjusted for use with persons with developmental disabilities.

Accountability, Quality and Outcomes. DHH intends to develop and include strict accountability standards for our chosen MCO partners. In the development of the State's Medicaid managed-care model, Bayou Health, DHH learned lessons from other states, including the need for the ability to both financially sanction and reward plans for their performance. Based on feedback from stakeholders, this also includes the requirements for an 85 percent medical loss ratio (MLR), where at least 85 percent of the premiums paid to the plan are spent on qualifying health services.

DHH intends to require plans to develop comprehensive and transparent quality strategies tailored to the needs of these populations, which also must be guided by and integrated with both existing and future state-driven priorities. DHH also intends to place a strong emphasis on public reporting. Contracts with MCOs will require ongoing reporting of selected Health Effectiveness Data and Information Set (HEDIS), selected Consumer Assessment of Healthcare Providers and Systems (CAHPS), and other state-determined LTSS measures specific to these services and population.

State capacity to provide monitoring and oversight are also critical. Operational oversight of the MCOs will be assigned to highly qualified state personnel with decision-making authority necessary to proactively administer the plan in the public interest. The State will ensure an adequate number of staff are available to carry out monitoring and be responsive to MCO concerns related to state policies and processes. The State will also have partners in assuring accountability in the form of its required

contract with an External Quality Review Organization (EQRO), and contracted actuarial services.

The DHH will maintain a comprehensive quality measurement system to ensure the integrity of services to, and safeguard the health and welfare of enrollees in MLTSS. The guiding principles of CMS waiver assurances will be used. Monitoring and oversight will be conducted on an ongoing basis. These principles will be enacted in collaboration with the MCO, provider networks and local partners. DHH will establish outcome measures for MCO performance. Reports on these measures will be made available to the public.

Consumer Protections: The State envisions that MCOs will comply with DHH-established policies in regards to consumer rights and protections. MCOs will implement internal policies and procedures compliant with Olmstead, HIPPA, ADA and other applicable laws. In all consumer processes, MCOs must provide assurance of adequate supports for persons with disabilities to understand rights, responsibilities and options, and to exercise meaningful choice. The MCOs will provide assurance of accommodation for non-English speakers, deaf/blind, nonverbal, racial and ethnic minorities, homeless persons, and other historically underserved sub-groups, including access and accommodation for persons in rural areas.

Providers: Most states recognize that MCOs must be given time to develop their LTSS provider networks. Louisiana has already taken the position that MCOs will be given this time post-award and do not need to engage in this activity prior to release of an RFP and award of contracts. Through advisory panels or other mechanisms, MCOs may also involve local consumers in network development.

Another key consideration is the extent to which MCOs will be required to engage existing providers participating in the FFS system at the time of transition. The MLTSS advisory group recommendation was that members be allowed to continue with their existing providers for a period of time post-enrollment in MLTSS, regardless of whether those providers contract with the MCOs or participate in the MLTSS system.

For some provider groups, DHH is considering mandating contracting with all enrolled providers.

In other instances, DHH can make available provider profile and performance data to assist MCOs in selecting high-quality providers. MCOs will be responsible for identification of service gaps and engagement in community advocacy and other initiatives to address these service gaps.

Conclusion: As the State continues to actively involve stakeholders and experts in the creation of this system, we are hopeful that we will be able to create a high-quality system of care for all individuals in the LTSS care continuum. MLTSS provides an opportunity for the State of Louisiana to continue its work in delivering coordinated care while, at the same time, bending the cost curve. MLTSS is the next step in reforming Louisiana's LTSS system and will continue the work the State has done in the past including providing the appropriate balance between providing care in institutional and community settings. The State looks forward to further developing its proposal and working with CMS towards the implementation of this systems transformation.

Appendix A:

MLTSS Advisory Group Members

- ▶ AARP Louisiana
- ▶ Advocacy Center
- ▶ Consumer Representative, Adult
- ▶ ALS Association of Louisiana
- ▶ Arc of Louisiana
- ▶ Adult Children Caretaker Representative - Alzheimer's Association
- ▶ Community and Residential Services Association (CARSA)
- ▶ Consumer Representative, Developmental Disabilities - People First of Louisiana
- ▶ Families Helping Families
- ▶ Geriatric Specialist
- ▶ Governor's Office of Disability Affairs
- ▶ Governor's Office of Elderly Affairs
- ▶ Holy Angels Residential Center
- ▶ HomeCare Association of Louisiana
- ▶ Human Services District Representative
- ▶ LeadingAge Gulf States
- ▶ Legislative Representative

- ▶ Louisiana Aging Network Association (LANA)
- ▶ Louisiana Development Disabilities Council
- ▶ Louisiana Health Care Quality Forum
- ▶ Louisiana Home and Community-Based Service Provider Association
- ▶ Louisiana Nursing Home Association
- ▶ Louisiana Support Coordination Alliance (LSCA)
- ▶ Louisiana Supported Living Network
- ▶ Mental Health America of Louisiana
- ▶ PACE Baton Rouge, Franciscan Missionaries of Our Lady
- ▶ Parent Representative, Developmental Disabilities
- ▶ Volunteers of America

Appendix B:

Long-Term Care Advisory Group – Meetings and DRAFT MLTSS Development Timeline

- ▶ **Advisory Group Meeting #1:** Thursday, October 3, 2013 – 2:30 p.m. to 4:30 p.m.
- ▶ **Advisory Group Meeting #2:** Thursday, December 12, 2013 – 10:00 a.m. to 2:00 p.m.
 - ◊ Work Groups:
 - (1) Accountability,
 - (2) Consumer Protections,
 - (3) Measuring Quality and Outcomes, and
 - (4) Stakeholder Engagement and Communications
- ▶ **Advisory Group Meeting #3:** Thursday, January 9, 2014 – 10:00 a.m. to 2:00 p.m.
 - ◊ Work Groups:
 - (1) Enrollment,
 - (2) Benefit Design,
 - (3) Care Coordination, and
 - (4) Populations
- ▶ **Advisory Group Meeting #4:** Thursday, February 6, 2014 – 10:00 a.m. to 2:00 p.m.
 - ◊ Work Groups:
 - (1) Focus on Rebalancing,
 - (2) Providers,
 - (3) Choosing our Partners, and
 - (4) Implementation
- ▶ **Public Webinars and Public Forum Meetings:** February 2014
- ▶ **Legislative Session:** March 10, 2014 to June 2, 2014
- ▶ **Advisory Group Meeting #5:** Early June
- ▶ **RFP Release:** Late Summer/Fall 2014
- ▶ **Concept Paper Submitted to CMS:** Summer 2014
- ▶ **Waiver Submitted to CMS:** Fall 2014
- ▶ **Deadline for Proposals:** (60 Days from Date of RFP Release because of magnitude)
- ▶ **Evaluation of Proposals Begins:** (Day following Deadline for Proposals or if Deadline is on a Friday then that Monday or Tuesday and continue for 30 days)
- ▶ **Announcement of “Tentative “or “Anticipated” Contract Awards:** (Since DHH can only recommend)
- ▶ **Deadline for Receipt of Signed Contracts from Awardees:** (7 days)
- ▶ **Submission of Signed Contracts to DOA/OCR:** (One week after end of DHH and/or DOA protest periods/resolution)
- ▶ **Approval of Contracts by DOA/OCR:** (3 weeks per DOA if everything is in order)
- ▶ **Assignment of Members to a Health Plan and Notice to Them:** (First Day of Month Prior to Go Live Month)
- ▶ **Go Live Date:** (TBD)

Developing a System of Managed Long Term Supports and Services in Louisiana

For additional information, please visit
MakingMedicaidBetter.com/LongTermCare

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