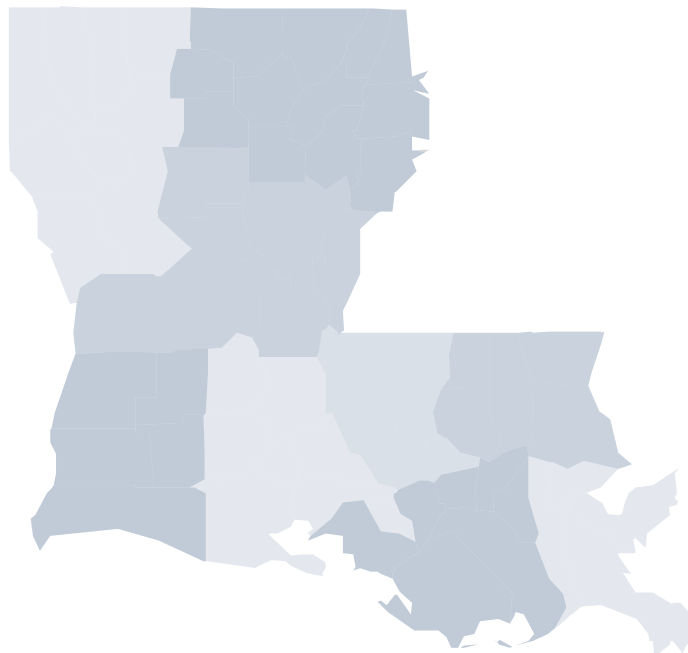




# **UPDATE ON LOUISIANA'S CONCEPT FOR MEDICAID MANAGED CARE FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (I/DD)**



**SEPTEMBER 2014**

## Background

Over the past decade, the Louisiana Department of Health and Hospitals (DHH) has engaged stakeholders in a comprehensive effort to reform Louisiana's long-term care system by expanding access to community-based options, improving the cost-effectiveness and sustainability of those options, and implementing institutional downsizing and community-transition strategies. These efforts have been guided by the 2006 Plan for Immediate Action and Louisiana's Plan for Choice for Long Term Care, and have proved effective in lowering the per-person cost of home and community-based services (HCBS), improving HCBS quality, and increasing both the number and proportion of persons receiving services in the community.

Recent transformation in service delivery to other Medicaid populations in Louisiana provide guidance to how Louisiana may achieve improvements for individuals with I/DD. Much of Medicaid delivery in Louisiana has migrated to a managed care delivery system from our legacy fee-for-service (FFS) delivery system. The Louisiana Bayou Health program provides physical and basic behavioral health services and care coordination for Bayou Health enrollees. The Statewide Management Organization (SMO) under the Louisiana Behavioral Health Partnership (LBHP) provides care coordination, behavioral health services, and specialized behavioral health services to LBHP enrollees. While these programs have met many goals of the Department in relation to included populations and the overall Medicaid program, these programs are not focused on individuals with I/DD. Thus, achieving desired outcomes with the I/DD population has been challenging.

## The Current Dilemma

We feel there are great opportunities in key and critical components of the Medicaid program as related to serving persons with I/DD. Areas that are in need of improvement include health outcomes, efficiency, access and demand, and programmatic simplicity for beneficiaries and the State. Our unique challenges in Louisiana are addressed below.

## *Opportunities for Improved Health and Behavioral Health Outcomes*

Louisiana has been very effective over the past several years in improving its system of community-based alternatives to institutional long-term care. Benefits and services have been expanded. Data-driven systems for quality measurement and quality assurance have been established. Most importantly, average per person costs have and are being reduced through systems of assessment-based resource allocation and an emphasis on providing individuals with opportunities to access employment and integrated supports. Louisiana has an active Money Follows the Person (MFP) transition program for aged/disabled and I/DD populations, and the largest Permanent Supportive Housing program supported by a state in the country. Beginning in summer 2014, many persons who are projected members of I/DD MLTSS have had the opportunity to opt into the Bayou Health managed care system.

While these positive changes have been made, improvements in HCBS alone are not sufficient to improve overall health outcomes for this high-risk, chronic care population.

Co-occurring behavioral health challenges for individuals with I/DD occur at a higher rate than amongst those without I/DD. While individuals may differ in need for and intensity of any ongoing behavioral health supports, the initial involvement of a behavioral health professional with expertise in assessment and support of individuals with I/DD is necessary to identify the likely factors impacting the behavioral presentation and to dialogue and collaborate with other professionals involved in acute and LTSS care. Although the LBHP has resulted in access to a wider array of more specialized and community based behavioral health services for many Medicaid recipients, there remains a nation-wide problem regarding behavioral health services access for persons with I/DD. Traditional federal behavioral health structures have been a point of debate with CMS in regards to structuring of service definitions and supports goals that include I/DD. As recently as

June 2014, a national meeting of state I/DD system directors highlighted the challenges of addressing utilization, access, and coordination in traditional Medicaid behavioral health systems, including in the 1915(i). The consensus of state directors and national direction in I/DD behavioral health is that offering specialized I/DD options to overlay or replace traditional behavioral health systems is the best remediation within the traditional system limitations.

Persons with co-occurring I/DD and behavioral health concerns have unique needs. Use of the more traditional serious mental illness (SMI) approach does not ensure coverage and access to all individuals who may need services from a behavioral health professional. Family/staff training options, wraparound supports, case conference/ collaborative activities, and intensive day to day supports do not diminish as needs in adulthood for many individuals with I/DD and co-occurring behavioral health needs.

Effective assessment and support for individuals with I/DD and co-occurring behavioral health needs represents a specialized area of behavioral health services. The cross over between behavioral health and LTSS supports needs to be well-planned and coordinated, with emphasis on the unique lifespan and supports related issues of persons with I/DD. For some individuals, these options must be intertwined and coordinated in a meaningful fashion; whereas for others with more intensive needs, the ability to have a single provider responsible for coordinating across all hours of each day is imperative for positive outcomes and cost effectiveness.

### *Opportunities for Improvements in Efficiency*

Louisiana believes savings can be realized through improved coordination of a complete package of Medicaid benefits, savings that can be reinvested in shrinking or eliminating HCBS waiting lists and in addressing the necessity of providing an accessible and appropriate service array for persons across the lifespan. Potential areas for savings through improved coordination and payment systems include reduction in unnecessary and avoidable hospitalizations and readmissions, reductions in polypharmacy and inappropriate prescribing practices, more effective use of

behavioral interventions to address behavioral health issues as drivers of higher acute and long-term care spending, and improved diversion and transitions managements as complements to continued MFP rebalancing efforts. For example, in looking at current system utilization, we see that thirty-seven percent (37%) of acute care costs of current I/DD waiver recipients are in pharmacy.

### *Access and Demand*

Though Louisiana has experienced considerable success in expanding community-based options and rebalancing, limited funding for optional 1915 (c) waivers combined with growing demand for services have meant continued substantial waiting lists for I/DD HCBS waivers. Individuals at three-hundred percent (300%) of SSI can readily access institutional services while individuals at the same level of financial eligibility face lengthy waiting lists for HCBS. Some persons have been waiting more than seven years for a New Opportunities Waiver (NOW) offer.

### *Administrative Complexity*

The current system of care for individuals needing LTSS suffers simultaneously from lack of coordination and duplication of coordination efforts. Though Bayou Health and the Behavioral Health Partnership have been significant in expanding access and improving outcomes for most Medicaid recipients in Louisiana, there still remains significant room to improve and simplify the system of care for Louisiana's I/DD service recipients. Combining both FFS and capitated components, and accessed through four 1915 (c) waivers, multiple state plan services, Bayou Health for acute care of certain non-dual LTSS recipients, and a concurrent 1915 (b)/(c)/(i) behavioral health program for some LTSS populations depending on clinical criteria and what authority they are qualified or excluded under, it is a complex system that can be confusing for consumers and providers to understand.

Furthermore, the current I/DD system offers up to six support coordination options which can, in certain circumstances, be delivered in duplication. Stakeholders have established expectations for an improved customer experience and a system that is much easier to navigate at key life transitions,

especially as I/DD supports and service needs are ongoing. Streamlining administrative processes will also support improved care coordination and achievement of health, behavioral health, and quality of life outcomes.

## Stakeholder Input

OCDD has been working with stakeholders since November 2012, with a system transformation effort that has directly involved more than two hundred (200) family members, consumer advocates, providers, support coordinators, legislators, administrative partners, and other stakeholders in workgroups, focus groups, information exchanges, and interactive stakeholder meetings to actively shape the direction of our transformation and move to managed care. From the beginning, the transformational effort established goals for the customer experience, with the system design, flows, and components produced by workgroups aimed to create the experience the larger stakeholder contingency outlined early on. We focused on establishing expectations for our system, with consensus around five measurable transformational outcomes:

- ▶ Serving more persons in HCBS
- ▶ Achieving cost effectiveness in HCBS
- ▶ Reducing institutional reliance in both public and private settings
- ▶ Providing access to appropriate services based upon need
- ▶ Increasing utilization of appropriate natural and community supports

OCDD maintains a family/advocacy driven Core Stakeholder Advisory Group for ongoing feedback and review of transformational developments. This group convenes monthly. Many members of the Core Stakeholder Advisory Group are also members of the Department's Managed Long-Term Supports and Services (MLTSS) Advisory Committee. This has facilitated informed discussion of important components of I/DD system design and direction.

In addition, OCDD holds quarterly stakeholder meetings broadcast statewide to provide transformational updates and to respond to questions. OCDD utilizes this opportunity to highlight

important MLTSS information and direct stakeholders to the Department's MLTSS development webpage.

## MLTSS for Individuals with I/DD: Goals of a Redesigned System

The July 21, 2014, call between the Louisiana Department of Health and Hospitals and CMS provided an opportunity for the Office for Citizens with Developmental Disabilities (OCDD) to highlight the progression of stakeholder involvement in MLTSS development, as well as to outline important goals for the convergence of the developmental disabilities system transformation efforts and MLTSS implementation. The following expectations for the I/DD MLTSS system were identified:

- (1) All persons, even those waiting for LTSS, should receive comprehensive, front-end support coordination that is outcomes-based and delivered by someone with I/DD expertise. There is large-scale consensus among Louisiana's I/DD stakeholders that making front-end support coordination available to all persons is the first and most important step to addressing system efficiency and any wait for LTSS. Stakeholders have requested that assessment, discovery, planning, ongoing coordination, and monitoring be available to all persons in the MLTSS system. When OCDD and stakeholders voice goals of "serving all persons" in MLTSS, the first phase of doing this is by providing competent, I/DD specific support coordination;
- (2) The MLTSS system must address the lifespan, starting from birth and moving through end of life, better incorporating the early intervention program and applying age-appropriate planning and services that emphasize key life transitions, enhance effectiveness of family caregivers, and support self-determination.
- (3) The MLTSS system must include an aggressive waiting list reduction strategy, developed from assessment of persons currently on the waiting list, to be crafted

and implemented with a target to over time end the wait for the services people need;

- (4) System improvements must address our top reason for failure of community placement: behavioral health challenges.
- (5) The MLTSS system should include an improved HCBS package, as identified through system transformation work, utilizing flexibility within the authority in order to achieve maximum compliance with new CMS HCBS guidelines. The HCBS service package will also:
  - a. Strive for transformation and innovations in employment,
  - b. Provide maximum choice and flexibility within a broad menu,
  - c. Provide a variety of support models that respond to changes in need and emphasize community integration and enhancing independence.
- (6) The MLTSS system will support rebalancing by applying discussion of living setting in all plans, with an emphasis of ensuring individuals understand all support options available to them in HCBS, and address transition planning from acute medical and behavioral health settings from the point of admission. The MFP transition program lessons learned will be incorporated in the system as permanent elements of MLTSS. The MFP program will continue, along with related benchmarks.
- (7) The MLTSS system will facilitate program and administrative simplification evident at the service recipient and provider levels. The state will operate the system using a single waiver, if at all possible. A single waiver would offer flexibility and opportunity to use a variety and intensity of supports that address lifespan issues and provide appropriate services for prioritized, unaddressed need.

We believe that the 1115 research and demonstration authority is the best and most appropriate vehicle to accomplish the expectations

outlined above for I/DD MLTSS. The context provided in the discussion of the current dilemma emphasizes the challenges of converting an existing system that is not meeting the population's needs to managed care. Coupled with this, Louisiana is seeking to be a leader among states by demonstrating long-term success in MLTSS for I/DD populations through the use of commercially-available MCOs. Louisiana's approach will test a true procurement model and partnership with a private/commercial managed care plan by applying a carefully planned, phased and measured approach.

## The Demonstration as the Solution

We propose to use a two-phased approach to implementation of I/DD MLTSS in order to best support appropriate planning and technical assistance to the MCO and providers. Within this approach, we assert state oversight will result in better infrastructure to support beneficiaries' needs, inform a model that may be scalable in other states as they expand managed care to the I/DD population, and provide a singular path for state intervention and oversight of a comprehensive MLTSS system operated by a private/commercial managed care plan.

Phase I will implement managed care with administration of support coordination, primary/acute, behavioral health, and LTSS under the MCO. Support coordination, primary/acute, and behavioral health services will be administered at risk/with capitation; however, LTSS will operate non-risk/without capitation. OCDD system transformation has constructed significant changes to LTSS in order to better support rebalancing and consumer outcomes. In continuing to pursue these changes in a non-risk climate, we will strengthen the underpinnings of the current FFS LTSS system to prepare for the success of a full risk program in Phase II. Per system transformation recommendations, we will consolidate the four existing I/DD 1915(c) waiver programs into the 1115 demonstration waiver. At outset, the current four waiver programs will operate "virtually" as they do today, with a phase-out plan beginning in Phase I of MLTSS. This phase-out plan will transition persons to the consolidated



1115 waiver service package, a package that is designed, per stakeholder request for a single HCBS waiver, to address the lifespan and facilitate timely access to services. Persons not using one of the four current waivers at the time of MLTSS implementation will be directed to the consolidated 1115 waiver service package.

Phase I will require a significant shaping of MCO capability in I/DD specialized support coordination, primary/acute and behavioral health systems management. As stated previously, there is relatively little experience nationally in I/DD specialized supports within private/commercial managed care plans. We see an opportunity to work closely with the MCO in a data-driven partnership, first achieving process-based improvements in operations, person-centered planning, access, and quality measurement that, over time, result in measurable outcomes improvements for the population. In addition, of particular concern is assuring that the MCO is fully equipped and experienced to address consumer protections and rights issues for the I/DD population before moving to risk-based/capitated LTSS. We believe that the careful planning of Phase I is consistent with recommendations from the President's Committee for People with Intellectual Disabilities Managed Long-Term Supports and Services, 2012 Report to the President and CMS guiding principles for MLTSS programs. Phase II of the MLTSS system will apply the tools developed and implemented in Phase I and capitalize on the enhanced experience of both the plan in administration of population specific programs and state staff in monitoring and oversight.

### *Included Populations*

The Louisiana I/DD MLTSS system will support approximately 40,000 Medicaid eligible individuals from birth to end of life. Enrollment will be mandatory.

Functionally eligible persons will include infants and toddlers meeting the state's early intervention program eligibility criteria as determined by the EarlySteps single point of entry (SPOE) and persons of all ages with a current/grandfathered developmental disabilities statement of approval (SOA) issued through OCDD SPOE, as operated by regional human services districts and authorities. The "pathway"

into I/DD MLTSS is only through disability eligibility certification of persons from a SPOE. SPOEs will not be a function of a MCO.

Our intention is to have the early intervention program operated in total by the MCO. The administrative function that supports non-Medicaid eligible children will be operated by the MCO. This should result in a seamless system for families regardless of Medicaid eligibility.

Infants and toddlers qualifying for the state's early intervention program will benefit from comprehensive, integrated coordination of primary/acute, behavioral health, early intervention, and LTSS benefits. While not all children who qualify for early intervention segue to the traditional developmental disabilities service system, we see that the highest risk and most complex need children with I/DD supported by those families in the most need of support to maintain a home placement are often first identified by the early intervention program. The partnership of Louisiana's early intervention program with the traditional I/DD service system has been invaluable in shaping approaches to lifespan planning and more effective inclusion of caregiver and natural supports in support strategies. The principles of person-centered planning, applying age-appropriate planning and services that emphasize key life transitions, working to enhance effectiveness of family caregivers, and striving for systems that support self-determination are shared values in both the early intervention and traditional I/DD systems.

Beginning in 2009, the MFP transition program worked to demonstrate the effectiveness of combining the state's early intervention program with the I/DD 1915(c) waivers in first transitioning children from nursing facilities and then implementing a diversion program for children with lengthy hospital stay referred for nursing facility placement. This program has had incredible outcomes, with over ninety percent (90%) of persons transitioned remaining in the community, reducing the nursing facility population of persons age nineteen (19) and under [reporting age range defined by MFP target group] to fewer than ten children (10) statewide, and showing significant fiscal efficiencies in post transition costs. Simply put, we believe that a large component of the efficacy and success of a full lifespan I/DD

MLTSS system relies on early identification and effective coordination and interventions occurring with plan members and their family support networks. Inclusion of the early intervention program in I/DD MLTSS is key to success of the proposed 1115 demonstration. Partnering the early intervention and traditional I/DD systems in MLTSS will support engaging families as early as possible in coordination and collaboration, which research shows may be integral in changing the trajectory of how families participate in the service system long term and also supports sustainability of LTSS systems in the face of growing demand for HCBS.

## **Medicare/Medicaid dual eligible persons will be included in I/DD MLTSS.**

### *Included Services and Settings*

All plan members will receive support coordination, regardless of living setting. Support coordination will be based in recent CMS HCBS guidelines for support coordination and planning. An LTSS and person-centered planning specialist or an early intervention planning specialist (applicable to EarlySteps program participants) will act as lead support coordinator. The support coordination system will incorporate a secondary level of acute and behavioral health case management. Acute and behavioral health case management will be provided based upon assessed level of risk/intensity of need, with licensed professionals acting as case managers for persons with highest level of risk/intensity. We believe that this support coordination “team” will contribute to better outcomes for individuals with I/DD and an improved experience for service recipients, their families, and providers.

All acute, or physical health, services for children and adults will be included in I/DD MLTSS and will be managed by the MCO within a risk-based/capitated payment. These services include, but are not limited to, physician services, hospital services, and EPSDT. We propose no change to state plan hospital or clinic services. Appropriate “value added” and “in lieu of” service options will be encouraged, including offering hospital sitter services. Acute care services administration will

apply I/DD specific risk mitigation, planning, and performance indicators. In addition, pharmacy services will be administered with I/DD specific best practice guidelines. We will transition voluntary enrollees from Bayou Health to I/DD MLTSS per the I/DD MLTSS phase in plan; no persons with an EarlySteps or OCDD SOA will remain in Bayou Health.

The I/DD 1115 will include an early intervention service array, consistent with current EarlySteps program design, that is administered by the MCO using guidelines, authorization processes, and payment schedules specified and closely monitored by the Department.

Behavioral health services for children and adults will be included in I/DD MLTSS and will be managed by the MCO within a risk-based/capitated payment. These services include, but are not limited to, psychiatry clinic services, psychological services, inpatient behavioral health hospital services, and EPSDT behavioral health services. As in acute care, these services will be administered with I/DD specific risk mitigation, planning, and performance indicators.

Behavioral health services in the I/DD 1115 will be different than those in the current Medicaid system, in part to remove the serious mental illness access criteria that frequently prohibits persons with intellectual disabilities from qualifying for services. We will not include duplicative state plan residential behavioral health services, such as psychiatric residential treatment programs for juveniles. Instead, any persons served in these programs will transition to an appropriate I/DD alternative. In addition, we do not intend to include either the 1915(i) or the CSOC (b/c) waiver for children in the I/DD 1115 in whole. The I/DD specialized behavioral health package will replace these programs to more effectively identify and meet the needs of persons with I/DD who also have intensive mental health and behavioral support needs. At this time, approximately 1,100 projected members utilize these specialty programs under LBHP. Our first priority in Phase I of the 1115 will be to ensure specialized behavioral health services are available to these persons.

Current LTSS services included in the MLTSS system and managed or administered by the MCO from implementation of Phase I at non-risk/ without capitation, include:

- ▶ New Opportunities Waiver (NOW)
- ▶ Children's Choice Waiver (CC)
- ▶ Supports Waiver (SW)
- ▶ Residential Options Waiver (ROW)
- ▶ Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD)
- ▶ Nursing Facilities
- ▶ Long-Term Personal Care Services (LT-PCS)

In addition to the above, the consolidated 1115 waiver service package will offer LTSS from implementation of Phase I. This package includes services new to the I/DD population. LTSS administration will apply I/DD specific risk mitigation, planning, and performance indicators, incorporating the waiver assurance areas familiar to many stakeholders as well as enhancements founded in new CMS HCBS guidelines.

The complete service package for both behavioral health and LTSS in the 1115 will be detailed in a series of public information sessions prior to finalization of the waiver submission to CMS.

The 1115 operation will apply resource allocation principles, with an intended outcome that persons will be served in the most cost effective and appropriate setting, as determined by person-centered planning processes and utilization management strategies approved by the Department. Due to the complexity of resource allocation systems for persons with I/DD, the development, validation, and operational capacity building of this system will occur throughout Phase I. A level of need system will determine ability to request long-term institutional stay. Level of need assessment will be conducted by a third party not at risk under the MCO, consistent with conflict free guidance from CMS.

Data from the first year of Phase I will be utilized to move to Phase II. Phase II of I/DD MLTSS as operated with an 1115 will include the following:

- ▶ Full statewide implementation of the specialized behavioral health package, which is in development, testing, and capacity building in Phase I.

- ▶ Full statewide implementation of at-risk/ capitated LTSS.
- ▶ Implementation of the new Request for Services Registry design, per OCDD system transformation. With completion of assessment and person-centered planning for all persons listed on the current Request for Services Registry, detailed identification of any remaining unmet need, prioritization, and targeted reinvestment in the system to facilitate access to needed services.
- ▶ Full implementation of resource allocation principles to facilitate maximum portability and flexibility in benefits.
- ▶ Implementation of a broader array of specialized LTSS options that involve joint coordination and care provision at the provider level for persons with high intensity acute and/or behavioral health needs.
- ▶ Implementation of conversion, diversification, and repurposing supports to enhance system capacity and aimed to best meet the goals of the demonstration, including in providing specialized interventions and supports to maintain persons in appropriate settings and to support maximized community integration.

Phase II of I/DD MLTSS will see the consolidated 1115 waiver service package fully developed and incorporated in the array of available service options.

## Additional Information on I/DD System Design

### Provider Network

The MCO will be required to contract with all LTSS providers in the initial year of implementation. Service recipients may continue to receive LTSS services from the same provider unless they request a change. Behavioral health provider network strategies are under development.

Early intervention program provider guidelines and network specifications will remain the same.

We anticipate setting rate floors for behavioral health and acute services consistent with current state practices in managed care contracts. LTSS and early intervention program rates will be set by the Department in Phase I.



Provider payments will be paid based upon a schedule included in the RFP and resulting contract. The intention is to ensure all claims, including those in the non-risk/without capitation group, are paid with a quick turnaround.

In addition, we continue to work within the Department to simplify provider administrative functions in this shift to managed care.

### *Support for Plan Members*

Per MLTSS Advisory Group recommendations, the state will contract with an independent Ombudsman program.

Phase I will include intensive capacity building within the MCO in regards to population appropriate communication and responsive processes. We will assure the plan is fully equipped and experienced to address consumer protections and rights issues for the I/DD population within the 1115 resource allocation design before moving to risk-based/capitated LTSS.

### *Quality and Accountability*

MCOs serving the I/DD MLTSS population will have to obtain NCQA and URAC (pharmacy benefits) accreditation. Bayou Health, LBHP, and MLTSS programs will use the same External Quality Review Organization (EQRO) to perform federally required managed care review processes. Sharing

these accreditation and monitoring systems helps ensure that we are able to accurately gauge plan performance at a state and national level.

The MCO will survey consumers using the nationally certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the same survey currently used by Bayou Health. In addition, I/DD MLTSS will continue to use the National Core Indicators (NCI) survey, administered either by OCDD or by an independent contractor, to assess satisfaction, system performance, and quality of life areas.

In addition to the performance indicators discussed previously, money measures will be applied in high priority areas, including addressing rebalancing. Two performance improvement projects will span the term of the contract, the first being an employment initiative and the second related to pharmacy management. In establishing the components of the quality and accountability systems, including performance indicators, money measures, and performance improvement projects, we are committed to ensuring individuals have opportunity to fully engage in their communities, to work, and to have relationships.

We look forward to further discussion with our stakeholders regarding the continued development of the Louisiana I/DD MLTSS 1115 concept.

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

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