

## REQUEST FOR INFORMATION

### LONG TERM SERVICES AND SUPPORTS FOR PERSONS ENROLLED IN LOUISIANA MEDICAID

UnitedHealthcare Community Plan has extensive experience supporting states' goals of caring for the most complex populations served in Medicaid programs. As part of UnitedHealthcare Community & State, we currently serve more than 225,000 members in need of long-term services and supports in 10 states through models specifically designed to tackle the difficult issues Louisiana currently faces. For more than 20 years, we have developed, in partnership with states, models to reduce dependence on institutional care and overcoming historic institutional biases to rebalance long-term care to more cost-effective and beneficiary-focused community care.

As a contractor in Arizona's Long-Term Care System (ALTCS) since the beginning of the program we have supported the dramatic rebalancing efforts resulting in current nursing home reliance of less than 30% of eligible individuals as compared to greater than 90% reliance at the program inception. During this period, nursing home occupancy remained relatively flat while broad expansion was made to home and community based services ensuring more access to community alternatives while the aging disabled population grew.

UnitedHealthcare Community & State currently contracts with Arizona, Delaware, Florida, Hawaii, Kansas, Massachusetts, New Jersey, New Mexico, New York, Tennessee, and Texas to support the goals of improving the care for individuals in need of long-term care and will be implementing a Financial Alignment Demonstration in Ohio – including long-term services and supports – later in 2013.

As a current partner to Louisiana's Bayou Health, we have a keen understanding of the unique needs of Medicaid enrollees in Louisiana. We also understand the political environment in Louisiana and have been supportive of the State's clear goals of improving quality and sustainability through the implementation of managed care. We appreciate the opportunity to provide insight to the State based on our unique and extensive experience serving these individuals throughout the country.

#### Response Requirements

***Responders are requested to describe their approach to providing Medicaid health care services to the populations described here, include the following:***

**• Populations to be included;**

Individuals needing long-term services and supports represent the most complex populations served by Medicaid programs. They represent a broad spectrum of individuals unlike any other served within Medicaid. Creating solutions for young disabled, elderly nursing home residents or developmentally disabled adults requires thoughtful consideration in program design. While some may argue the benefit of creating population-specific solutions, our experience demonstrates that states are best served in creating comprehensive solutions for the entire population to limit administrative burdens and to encourage market acceptance of a managed approach.

In addition to the broad spectrum of populations and concerns of individuals in need of long-term care services, an added complexity of Medicare eligibility exists for the majority of these individuals. Dual eligibility often results in lack of coordination in an unmanaged system and highlights the impact of Medicare utilization on the long-term expenses of states. Many states have been reluctant to require individuals eligible for both Medicare and Medicaid to be included in managed long-term care systems due to the fragmentation of

the two systems. Leaving these individuals unmanaged, however, only results in ongoing and unnecessary reliance upon institutional care. Given the high percentage of individuals in need of long-term services and supports who are dually eligible, excluding them from comprehensive solution limits the impact to the State of improving quality and increasing community placement options. In addition, the opportunities to coordinate Medicare and Medicaid through demonstrations and plan-level integration highlight the comprehensive understanding of the need to create holistic, person-centered solutions from two bifurcated programs.

We believe the State should include the broadest population possible to minimize administrative burden of maintaining parallel fee-for-service models. This ensures several positive outcomes including better budget predictability for the most costly populations; sufficient membership for plan investment; market adjustment to managed care; and broad improvements in quality and outcomes. We recommend the state include all individuals eligible for long-term care services – including individuals currently being served by home and community based service waivers and nursing home residents. We recommend the State include individuals who are dually eligible for Medicare as well as those who are only eligible for Medicaid.

Individuals who are developmentally disabled require unique management approaches and can benefit from managed care. As we understand the unique nuances of Louisiana’s developmentally disabled population, there are significant opportunities to increase the number of individuals served in community settings. We believe they can be successfully transitioned at a higher rate to community placement and this can be effectively facilitated through managed care. In order to for the population to be transitioned, however, careful consideration must be made to rate setting methodology as well as the role of current waiver providers. Both issues are discussed in more detail in subsequent sections.

**• Best enrollment model for program;**

States have explored both mandatory and voluntary election models in managed long-term care. States that have adopted mandatory enrollment have demonstrated broader success, market and provider acceptance, as well as increased sustainability of the Medicaid program. The few states that have used voluntary enrollment models have not had demonstrated, systemic success. Individual election is slow and can result in adverse plan selection, thereby undermining the viability of the program in general.

Implementing managed care models for this complex population, however, requires significant resources to ensure appropriate assessment of complex individuals as well as the implementation of holistic, person-centered plans of care. In order to ensure seamless implementation, the state may consider a geographic, staggered enrollment in which geographies are implemented within a pre-determined implementation schedule. Should the state adopt a phased implementation approach, we recommend that geographies reflect natural patterns of care to minimize any unnecessary disruption in enrollee and provider relationships. In addition, we recommend the Department of Health and Hospitals (DHH) clearly articulate the roll out schedule at implementation to avoid any political or provider attempts at delaying a particular geography.

Our experience in supporting states in developing effective long-term care programs has proven the need to limit the number of health plans contracted to ensure a reasonable amount of enrollment to minimize any negative risk small membership. Furthermore, the State should consider the development of an enrollment algorithm that balances types of membership among plans. In other words, it is important that plans have relatively similar numbers of individuals served in the community as well as those served in nursing homes and those who are dually eligible for Medicare and Medicaid. As described below, the financing model which we believe is most effective at aligning incentives to improve care and support rebalancing efforts will also rely upon balancing the complex members to be served through thoughtful auto-enrollment methodologies.

After the initial year or two of the program, DHH may consider the use of an enrollment algorithm that supports higher levels of enrollment to health plans that are meeting quality criteria set forth by the State. As described below, we believe any quality monitoring program and, therefore, any related enrollment model should be designed to reflect quality outcomes over several years.

Transitioning to a managed long-term care program requires appropriate identification of individual needs and alignment of appropriate resources. To accomplish this, given the complexity of assessments on such a population, we suggest the state allow for managed care organizations to risk stratify and prioritize assessments based upon the risks of the members it serves. Managed care organizations should be required to maintain a continuity of current plans of care until such time they are able to complete assessments and appropriately align services based upon these assessments. This model requires plans to strategically identify individuals at the highest risk of costly utilization while appropriately incentivizing them to complete assessments in a timely fashion.

**• *Supports and services (Medicaid and non-Medicaid funded) essential to include in the model ;***

Programs that are maximally comprehensive are best designed to improve quality and utilization while minimizing any unnecessary fragmentation and cost shifting. We believe managed long-term care programs should include all Medicaid benefits included in the State Plan. This includes all Medicaid acute benefits as well as long-term care benefits such as nursing homes and personal care attendants. Likewise, all appropriate 1915 (c) waiver benefits should be included to support the efforts of the state to rebalance long-term care. 1915 (c) waiver benefit inclusion will be dependent upon population served in the program. Based on our understanding of current 1915 (c) waivers, we believe Community Choices, Adult Day Health Care, Personal Care Services, New Opportunities Waiver, Supports Waiver, and Residential Options Waiver should be included assuming the state includes elderly, disabled, and developmentally disabled individuals into the managed long-term care program. The state may choose to include Children’s Choice waiver as well as children currently covered by the New Opportunities Waiver who are under the age of 18. If DHH includes children in the program design, it should ensure that participating organizations can demonstrate a model to support children which includes appropriate providers and understanding of the dynamics of caring for disabled children and supporting their families.

Given the interdependency of physical and behavioral health for a significant number of individuals who are eligible for long-term services and supports, we suggest DHH include behavioral health in the program design. This will encourage holistic consideration of the enrollees to be served and will also minimize any duplicative administrative costs and reduce the risk of cost shifting. In addition, we believe all Medicaid pharmacy benefits should be included to allow for identification of care opportunities and development of holistic, person-centered care.

For individuals who are eligible for both Medicare and Medicaid, we encourage the state to include all wrap-around Medicaid benefits – including cost sharing, pharmacy, and behavioral health – as well as the long-term care benefits included in the State Plan and 1915 (c) benefits as described above.

To ensure a health plan’s ability to maximize community placement options, we suggest that DHH limit any waiting list or slot barriers that may exist with current waivers. While these are often used to control the number of individuals served in waiver programs, they can become a hindrance in managed long-term care programs. In other programs with existing, prescriptive waiver waiting lists, individuals who would otherwise be eligible for community placement have had to wait until a slot is available. It is very important to ensure that waiver services be eligible for individuals who are appropriate for community placement.

In order to expedite community placement, we also suggest that health plans have the ability to determine eligibility for waivers with appropriate oversight from DHH or other agencies as appropriate. This model minimizes any unnecessary delay to repatriation and ensures broad flexibility for health plans to support DHH’s goals of rebalancing long-term services and supports.

**• *Approach to conflict-free case management;***

Conflict-free case management allows for individuals to be ensured that the benefits provided and counsel of care managers is free of unnecessary bias. We believe managed care can offer completely conflict-free case management through the effective program design. First, the assessment of individuals to identify needs should be completed through the use of comprehensive assessments that identify physical, behavioral, social,

and functional needs. Comprehensive assessments will identify individual needs which can subsequently be tied to the allocation of benefits and services. Secondly, managed care organizations typically serve as the facilitator of benefits and services rather than the direct deliverer of services. As such, we do not direct individuals into care that is directly provided by us minimizing any inappropriate influence.

Our experience has shown that individuals in need of long-term care services are best served through a multi-disciplinary approach that is directly matched to their needs. For instance, an individual who has primary behavioral health needs is assigned a care manager who is a behavioral health specialist. This care manager supports the member by aligning a multi-disciplinary team to address the other physical, social, and functional needs of the individual. This multi-disciplinary care team approach further minimizes conflict that could arise in care management and creates a model in which the comprehensive needs of the individual are assessed and addressed through allocation of benefits and services.

The assessment tools used are fundamental to ensuring a person-centered and conflict-free approach. Comprehensive assessments should be broad enough to uncover any needs of an individual and should directly link to the services to be provided removing any subjectivity or unnecessary conflict in services to be provided. We also believe that managed care organizations should be allowed to use proprietary assessment tools following approval by the State. Assessments serve as the foundation for effectively managing individuals and, therefore, are best served when the assessments have been specifically developed to compliment the comprehensive systems such as claims, case management, and customer service.

In addition to comprehensive assessments, alignment of services based upon the assessments, and the support of a multi-disciplinary care team, we believe conflict-free case management is supported through the development of an effective and robust model of inter-rater reliability. This approach monitors assessments and alignment of benefits and services to ensure consistency between care managers and removes subjectivity that might exist from one care manager to another.

**• *Inclusion of behavioral health;***

As mentioned previously, the complex needs and co-morbid conditions for many individuals served in long-term care programs and the interdependency between physical and behavioral health, requires a comprehensive benefit design, including behavioral health benefits. Fragmentation caused through the carving-out of behavioral health benefits establishes incentives to cost shift and leaves the beneficiary subject to two systems which may not take into consideration the impact on one another. Our experience has shown a holistic approach to person-centered care, including a broad benefit design, directly improves quality and outcomes.

In addition to the important impacts on individuals served in long-term care programs, including behavioral health minimizes administrative burden to managing bifurcated systems. The State is better positioned to ensuring contractor compliance and responsiveness by creating a model in which a limited number of contractors are chosen to support the goals set forth by the State.

**• *How the system will use evidence-based best practices for treatment and patient care;***

Evidence-based best practices are fundamental to improving the care of individuals with chronic and co-morbid conditions. Health plans should be required to demonstrate an ability to identify both gaps in individual care as well as providers who can benefit from education regarding evidence-based interventions. Health plans should have evidence of their experience and tools used to ensure care managers have a clear understanding of evidence-based best practices.

These tools should be used to identify individual providers or broader geographies that are not employing evidence-based practices. This analytical capability should be directly linked to interventions, outreach, educational opportunities employed to increase the adoption of evidence-based best practices. In addition, health plans should have the ability to perform ongoing monitoring to ensure broader adoption.

Evidence-based practices have historically been focused on acute and chronic condition management rather than long-term care. We strongly support the application of nationally recognized evidence-based best practices for these types of conditions and believe it is an opportunity for DHH to partner with managed-care plans to develop innovative best practices for long-term services and supports. We have extensive experience demonstrating an ability to move enrollees to less restrictive settings as well as identify individuals who are at risk for future placement thereby delaying or avoiding placement altogether. We believe this experience will be helpful as DHH shapes its thinking about the best approaches for Louisianans.

**• *Identify partnerships that might be formed;***

Given the very local nature of care delivery for individuals in need of long-term care, it is important for contractors to appreciate how to maximize the delivery system in place and to enhance it through expanded access and strategic relationships. For many provider types, including nursing homes and home and community based providers, our experience has shown that ensuring provider stability is fundamental program success. For nursing home providers, we believe the vast majority of providers should be required to participate with all managed care organizations. Only providers demonstrating either an unwillingness to embrace managed care or those with a proven history of poor quality be excluded from provider networks. This is particularly true during the initial implementation of the program. Following a reasonable implementation time-frame – three years as an example – health plans would have the ability to create more limited networks that align to the needs and geography of the members they serve. Furthermore, we believe the State should maintain the role of establishing rates for nursing homes to minimize political objection to the introduction of managed care into the long-term care program. This should, however, not limit the ability of a plan to create incentive models for high quality providers. In order to ensure both plan and provider engagement in network development, the State should institute a model in which providers are required to participate in networks and if they choose to not participate, their reimbursement would be reduced at least fifteen percent below Medicaid rates to ensure appropriate incentives.

Similarly, the local and small provider make up of home and community based providers requires plans to have expansive networks which include all current Medicaid providers in good standing. The very personal relationship between beneficiaries and providers of home and community based services requires plans to create broad networks rather than more traditional limited managed care networks. Given the current reliance upon institutional care in Louisiana, it is assumed that increased access to home and community based services will need to be developed. To this end, the State should encourage the participation of health plans with experience of developing programs for individuals in need of long-term care as well as those that have demonstrated an ability to expand access and engage providers to diversify and increase their span of influence.

Partnerships and strategic relationships have developed in existing long-term care programs. The nature of these relationships differs dramatically from one program to another. The most effective models, however, are those in which health plans are encouraged to demonstrate an ability to work locally and create solutions for the members served rather than those that have dictated that relationships must exist with specific types of community-based organizations. It is highly likely that health plans will come with a spectrum of experiences which may require plans to explore strategic community-based alliances to support their deficiencies or their particular approach to care management. Therefore, the State may consider both experience in developing strategic relationships as well as Louisiana-specific plans to develop such relationships as differentiators rather than dictate certain relationships must exist. This only creates artificial linkages and can develop unintended consequences of fragmentation and increased program costs and oversight demands.

**• *Education and outreach (for providers, Medicaid enrollees, and stakeholders) necessary prior to implementation;***

Educating individual beneficiaries, their families and caregivers, stakeholders, and providers effectively can be the basis for a seamless implementation as well as the foundation for long-term success. Each group requires a

slightly different approach, but our experience has shown that transparency in the process and reasonable engagement in providing feedback for all audiences will minimize the risk for political obstacles.

Providers are key to ensuring the program be implemented well. Providers who serve these complex individuals with social, functional and intuitional supports require a slightly different approach than typical managed care network development. To ensure minimal disruption in care and to ensure broad access to long-term services and supports, we believe the State should consider requiring provider participation for nursing homes, ICF—DD, and home and community based service providers for the initial two to three years of the program. This will ensure that health plans with less experience with the population will not attempt to apply traditional managed care network development approaches for providers with far more personal relationships than more traditional provider types. After the initial implementation period, health plans should be allowed to create more targeted, high quality networks. During the initial implementation period, health plans should be allowed to exclude any provider from its network upon demonstrating to the State that the provider has persistent quality issues and/or is unwilling to support the goals of managed long-term care.

In addition to minimizing concerns of small networks often raised by long-term services and supports providers during the implementation of managed long-term care, we know that cash flow is extremely important to providers' ability to meet the needs of enrollees. Therefore, we believe the State should continue to establish the fee schedule for long-term services and supports providers. There should be, however, no limitation on a plan's ability to create incentive models to increase quality and to encourage increased access to services.

In order to ensure provider participation, particularly when groups of providers have demonstrated an ability to create obstacles for development of a long-term care program, the State should allow for the incentivization of providers by allowing plans to reduce payment below the Medicaid fee schedule for providers who choose to not participate in managed care networks. Our experience that meaningful reductions in payment – 80 – 85% of fee-for-service – results in broad participation and reduces the risk of delayed implementation due to lack of provider participation.

Demonstrating to providers that the implementation of managed long-term care is not intended to immediately shrink the volume of providers nor is it intended to affect the fees paid to providers who choose to participate is vital to market acceptance. Education of these protections will minimize any unnecessary implementation challenges.

Stakeholders are often key to both acceptance of a new model as well as minimizing concerns directly from enrollees and their families and caregivers. Since stakeholders will likely represent a very broad spectrum of interested parties, the State should find opportunities to engage the group in whole as well as coordinate opportunities to allow for the solicitation of their feedback and suggestions. This process, however, should be closely contained by the State with clear expectations of program design elements which may be affected by stakeholder engagement. We would recommend the State develop a stakeholder advisory group to solicit engagement through the implementation of the program. On an ongoing basis, health plans should be required to develop advisory groups including stakeholders, providers, enrollees, and caregivers to help inform health plans' ability to effectively improve quality and maintain high levels of customer satisfaction.

Educating enrollees, their families, and caregivers is vital to minimize concerns about the introduction of a managed care model. The goals of most managed long-term care programs align with those of the majority of individuals served in them, such as community placement, person-centered care, and self-direction. Laying out the benefits to enrollees early on will minimize misperceptions of the loss of control often believed to be inherent in managed care.

Organizations that directly impact and influence enrollees should be engaged in an education campaign prior to implementation. Engaging organizations such as area agencies on aging (AAAs), state health insurance programs, senior centers, disability resource centers, and others will create a network of educated resources for individuals to turn to for advice and affirmation of the benefits of the program. Organizations such as AAAs

or other waiver providers that might currently be providing care should be engaged to communicate their ongoing role with the populations to be served. As mentioned previously, health plans should be encouraged to create relationships with these providers as appropriate to support their own particular care delivery model. Orienting these influential organizations along with providers will create an informed market place that will support enrollee acceptance as enrollees and their families and caregivers will ultimately look to them for guidance.

Health plans play a very important role in educating and preparing the market place for the implementation of a new long-term care program. Choosing health plans with a proven track record of community engagement and long-term supports and service provider network development will be key to the success of implementation in Louisiana. We know that engaging individuals who impact the care and decisions of these complex populations is significantly different from a less complex Medicaid population such as that currently served by Bayou Health. As such, the Department of Health and Hospitals (DHH) should carefully consider the skills, background, proposed models, and track record of health plans interested in participating in Louisiana and their ability to effectively engage the community in support of implementing managed long-term care.

**• Issues DHH should include in any Request for Proposals;**

As mentioned above, DHH should expect health plans interested in supporting the development, implementation, and management of a long-term care program should have a demonstrated track record in understanding the complex needs of the enrollees as well as a proven ability to engage with appropriate providers and stakeholders. Experience in developing and maintaining long-term supports and service networks and providing ongoing support to these providers should also be demonstrated by plans interested in participating in Louisiana. We suggest DHH require health plans to demonstrate effective plans for network development, provider support, as well as examples of health plans' ability to increase access to long-term services and supports.

The approach to clinical management should be a highly valued ingredient to the request for proposals. Similar to network and provider engagement, health plans should be able to demonstrate a track record of providing clinical supports to decrease reliance upon institutional care; increase access to home and community based services; increase quality and satisfaction; and decrease unnecessary acute episodes for non-dually eligible populations. We suggest DHH not create an overly prescriptive approach, but allow for plans to propose models that have been success for them in other markets. Consistent with avoiding an overly prescriptive approach, we would suggest DHH limit specific requirements for staffing ratios and allow for plans to propose appropriate models based upon their experience.

Assuming DHH sets minimal experience requirements in the request for proposals, we would assume plans would have experience in assessing the needs of individuals to be served. Plans should be able to demonstrate an ability to comprehensively assess the physical, behavioral, pharmaceutical, social, and functional needs of an individual and to align services based upon these comprehensive assessments. In addition to demonstrating experience, we would encourage DHH allow health plans to use propriety, proven assessment tools rather than requiring the adoption of standardized assessment tools. DHH should have the ability to review and approve assessment tools, but our experience demonstrates that the use of proprietary or customized assessments minimizes any operational challenges associated with linkages to claims payment and other systems.

To support the unique needs laid forth by DHH, plans should also have innovative solutions to support key goals such as increased community placement for the developmentally disabled population as well as decrease the overall cost of care for individuals and, therefore, the Medicaid program. Understanding the goals of the State as well as the unique nuances of individual markets within Louisiana that could impact things such as availability of appropriate and affordable housing is fundamental to a plan's success as well as the success of a long-term care program in general and should be an important element in considering appropriate health plans to participate in the program.

**• *Standard that should be met for cultural competency, sensitivity to the needs of the dual eligible population (if applicable) and accessibility prior to enrolling recipients;***

Understanding the needs of the population served in long-term care programs transcends a traditional view of cultural competency into a comprehensive and holistic approach to both population as well as individual management. In many instances, cultural competency is simply interpreted as ensuring access to customer service representatives, care managers, and providers who speak appropriate languages. We know, however, the very personal nature of managed long-term care programs requires a clear understanding of how enrollees should be engaged.

Given the social and functional needs of enrollees, plans must be able to demonstrate an ability to identify cultural differences and adjust for the appropriate delivery of services. Things like the manner in which different cultures treat end-of-life is vital to an effective model that is focused on the delivery of high quality care. Health plans should demonstrate a basic understanding of the challenges of caring for aged, disabled, and developmentally disabled populations and have demonstrated approaches to care management and enrollee engagement that acknowledges these differences. Health plans should also have an understanding of the cultures within Louisiana and have created clinical models, enrollee education, and/or strategic partnerships to support enrollees. Our national experience has taught us to approach each individual state and the geographies within that state with a fresh appreciation for the enrollees who will be served and develop an approach that draws upon our experience while not assuming states and markets will be like any other market previously developed.

Dual eligible enrollees have an added complexity simply due to the fact that many of their services are paid for and administered either by Medicare directly or by a Medicare Advantage plan. Health plans should have a keen understanding of the interdependencies and fragmentation of Medicare and Medicaid and should demonstrate an ability to integrate care where possible and leverage Medicare data and experience where available. Conversely, health plans with Medicare experience should not be equally evaluated as those with demonstrated managed long-term care experience. These plans typically do not have the intimate understanding of the delivery of long-term services and supports and often lack experience in assessing and managing social and functional needs. While they have experience in managing the acute needs of the population, we believe they are often ill equipped to understand the local delivery models and complexity of holistic, person-centered care.

As previously mentioned, health plans should have an understanding of providers who currently serve the needs of enrollees. This knowledge and proven ability to engage providers in other markets will support the cultural and clinical needs of enrollees. Accessibility to services is vital to supporting the goals of DHH, but more importantly, supporting the needs of enrollees. The very personal nature of services provided to many of these individuals – including personal care, homemaker, behavioral health, and institutional care – requires a robust approach to understanding the cultural needs of enrollees.

Our experience also indicates the need to be able to engage stakeholders in a meaningful way within individual communities. These stakeholders are often key to our ability to understand a unique market, but often provide significant insight into the nuances of individual cultures and communities. Stakeholders should be seen as an asset to health plans as they develop models specifically designed to support Louisiana and DHH's goals of a new long-term care program.

**• *Evaluation of success of the delivery model and over what timeframe;***

Measurement of success of implementing managed long-term care should be based on improvements in quality as well as utilization which will result in cost savings for Louisianans. It is also wise for DHH to have realistic expectations for when success can be measured. Implementing a managed long-term care program is often motivated by policy makers to reduce the costly reliance of institutional care and to focus more resources on expanding community-based options. These goals have been successfully demonstrated in existing programs over long periods of time. As in the case in Arizona, states have demonstrated, through the use of

thoughtfully designed managed care programs, to be able to rebalance long-term care driving to lower tax payer burden and higher levels of enrollee engagement and satisfaction.

The key to measuring success of increased community placement is to understand the speed with which rebalancing can successfully take place. Given, the current dependence of institutional care for the non-developmentally disabled populations in Louisiana, the state should set expectations of rebalancing that rely more heavily on avoiding nursing home placement for individuals who become eligible for long-term care rather than measuring for repatriation of individuals from nursing homes to community settings. This is largely due to the fact that individuals become institutionally dependent in a relatively short period of time and once that dependence has been established, repatriation can often be difficult. States with higher nursing home dependence than Louisiana – greater than seventy-five percent – could see individuals living in nursing homes desirous of community placement but in need of either support to transition or access to home and community-based services. Given the current dependence in Louisiana, however, we believe it is more realistic measure of success to measure avoidance rather than the movement of individuals from nursing homes to community settings. In light of this, our experience has shown that the state will see the most significant impact on measuring rebalancing efforts beginning in year three of a managed long-term care program.

Based on the current reliance on institutional care for developmentally disabled individuals in Louisiana, we believe rebalancing efforts can happen more rapidly assuming certain programmatic design considerations as well as ensured access to community based alternatives. The needs of the developmentally disabled population and lack of community supports such as appropriate housing options will greatly impact the effectiveness of the managed long-term care program. Managed care plans cannot be solely responsible to drive market changes and availability of basic resources which will be required to support rebalancing efforts. Significant investment of resources and alignment of supports will be an important element to ensuring safe and successful transitions to community settings. An example of systemic considerations for which DHH will have to consider in implementing managed care for developmentally disabled individuals is the creation of housing grants to support development of appropriate independent or congregate living options. If Louisiana is able to align resources and support the efforts of managed care plans to establish community options, we believe measurement of rebalancing efforts could begin as quickly as two years post implementation.

In addition to the fundamental goal of rebalancing as a measurement of success in managed long-term care programs, DHH can measure the impact of comprehensive coordination of services on acute utilization for the non dually-eligible population. Individuals who are not eligible for Medicare served in managed long-term care programs have demonstrated reduced reliance upon acute and emergent care. Through the use of tools to identify individuals at risk and the alignment of services through person-centered care plan development, Louisiana can expect to see reductions in acute utilization and an increase in primary and preventive services within the initial twelve months of implementation.

Other shifts in utilization which can be effective measurements of success include reduced use of medications for non dually-eligible individuals; reduced exacerbations of chronic conditions; increased identification of behavioral health concerns such as depression; and coordination of Medicare services assuming the appropriate availability of data and alignment of incentives.

Existing managed long-term care programs have had limited quality measurements processes to evaluate the effectiveness of managed care on home and community based services. We have developed metrics focused on measuring quality for long-term services and supports based on recommendations created through the efforts of the Centers for Medicare and Medicaid Services (CMS), Medicaid Directors, and others in the following seven domains:

- Participant Access
- Participant-Centered Service Planning and Delivery
- Provider Capacity and Capabilities

- Participant Safeguards
- Participant Rights and Responsibilities
- Participant Outcomes and Satisfaction
- System Performance

We recommend DHH consider creating a quality program based upon these seven domains rather than relying on quality metrics that may be used in Bayou Health for other less complex populations. In addition in determining appropriate HEDIS measures, we recommend DHH carefully consider those that are the most appropriate given the complexities of the population. Learning from experience in measuring for quality for dually eligible individuals through Medicare's STARS program as an example, DHH will be best positioned if it develops a quality program with significant sensitivities to the population served. This will avoid an unplanned negative consequence of questionable programmatic outcomes based on the misalignment of appropriately designed quality framework.

Similar to discussions above regarding timing of the measurement of success, we recommend DHH adopt administrative quality measures for the initial measurement year. We recommend DHH work with awarded health plans to identify appropriate quality metrics to demonstrate effectiveness of implementation. This will ensure health plan commitment to demonstrating quality during and following implementation through measures that are appropriate based on the maturity of the program. We recommend phasing in clinical measure in year two and that those measures for year two and beyond need to be realistically managed against appropriate goals. We have seen some states aggressively set targets for these programs which are unrealistic causing unnecessary critique of the State and health plans alike resulting in unnecessary political pressures.

***• Potential financial arrangements for sharing risk and rate-setting appropriate for population; Principles that should guide DHH in requiring specific approaches for rate-setting; and***

Like any Medicaid program, establishing rates and aligning incentives is fundamental to program success. Effectively structured rates will ensure maximum value through program implementation and less effective rate setting can result in disruptive and unnecessary program instability. In order to reduce the cost of long-term services and supports in Louisiana, we encourage the state establish a blended rate to appropriately incentivize community placement. The blended rate would take into consideration the costs of individuals currently served in the nursing home as well as those served in community settings. DHH should then apply a reasonable incentive to encourage the shift from nursing home reliance. As describe above, for the non-developmentally disabled population, nursing home to community placement shift incentives should be modest to account for the need to focus on nursing home avoidance rather than repatriation of large portions of the population from nursing homes to community settings. As more individuals are served in community settings, the rate would be adjusted to continue to reflect the lower costs of community care as well as ensure continued, meaningful incentives to ongoing rebalancing.

Given the concerns stated by DHH in the Request for Information regarding the continued increasing costs of waiver services, the blended rates can be structured in such a way as to encourage a certain degree of cost savings. We do recommend, however, that this be done in later years of program development as putting inordinate pressure on community placement resources can disrupt positive rebalancing momentum.

Individuals who are also eligible for Medicare must have separate rate development to adjust for the portion of expenses covered by Medicare rather than those covered by Medicaid. We suggest the same blended rate methodology be applied to the long-term services and support benefits to encourage rebalancing efforts equally for Medicare-Medicaid Enrollees. For acute Medicaid benefits, DHH can either include them in the cost experience used for the blended rate development or pay them separately with appropriate managed care savings assumptions. For cross-over liabilities, DHH should pay health plans a pass through of these expenses without the application of any managed care savings assumptions. Given the lack of ability to control

Medicare costs and utilization in a fragmented system, health plans will have limited ability to effectively reduce cross over liability.

For developmentally disabled individuals – as well as special needs children should they be included – DHH should establish unique rate setting methodology with a clear understanding of the limited ability to affect the costs associated with the population. This is particularly true until such time as there is clear evidence of available resources to support large-scale deinstitutionalization. As such, we recommend a cost plus methodology be established at the implementation of the program with an ability to revisit appropriate funding, savings, and incentives that would be mutually agreeable to the State and health plans alike.

Risk sharing models should be carefully considered to ensure appropriate alignment of incentives and reasonable approach to savings estimates. As previously discussed, Louisiana should establish reasonable assumptions for rebalancing initiatives. If set correctly, the blended rate establishes the incentive to avoid nursing home placement or repatriate as appropriate as well as avoid costly acute and emergent episodes. The blended rate should place an appropriate amount of pressure on health plans to look for as many rebalancing and cost containment opportunities as appropriate.

Should the state wish to create a specific risk sharing model in addition to the development of appropriately structured blended capitation amounts, we recommend there be equal up and down side risk for both the health plan and the State. In addition, if DHH adopts any quality incentives, we suggest that these be based upon appropriate quality measures for the population and the maturity of the program as previously mentioned.

In addition to effective rate design, one of the most powerful financial tools available in managed long-term care programs is individual cost effectiveness. As part of the waiver development with CMS, DHH should request individual cost effectiveness rather than programmatic cost effectiveness. This allows health plans to move someone to a nursing home at such time that the costs of maintaining them in the community exceed the cost of nursing home placement. Absent this tool, health plans have limited ability to force nursing home placement in instances where community placement is simply not feasible.

**• *Timeline necessary for implementation.***

Many things can affect an ideal time frame for implementation. Removing obstacles to network development – one of the most time consuming implementation tasks – can ensure a more rapid implementation. As mentioned above, encouraging participation for long-term services and support providers through a requirement for broad participation as well as reducing Medicaid payments below fee-for-service levels for all providers has demonstrated a significantly shortened implementation timeline in other states.

In addition, removing unnecessarily burdensome clinical and administrative requirements will also effectively reduce the amount of time needed for implementation. As discussed above, eliminating the need for highly specified relationships with community-based providers as well as allowing for the use of proprietary assessment tools can minimize implementation burdens. Recruiting qualified staff to support the enrollees is another significant step in implementing a managed long-term care program. Therefore, if DHH provides flexibility in the use of a variety of specialized individuals to serve as care managers as well as limits any burdensome staffing requirements, health plans will have an ability to meet more aggressive implementation timelines.

States have implemented managed long-term care in as little as six months, but this has occurred in less complex states than Louisiana. Therefore, based upon our experience, we believe nine to twelve months represents a more realistic time frame that will minimize implementation missteps.

**• *Potential risks and benefits of the approach(es) proposed.***

Some of the most significant risks DHH are likely to face in creating a managed solution for individuals in need of long-term services and supports can be overcome using the recommendations we have provided. Our experience has shown that effective education and engagement of enrollees, providers, stakeholders, and

others along with appropriate provider incentives, political barriers and challenges can be avoided or overcome. Effective rate development will ensure health plan and, therefore, program viability.

The most challenging opportunity in Louisiana will be related to the developmentally disabled population. Given the current institutional reliance, rebalancing will be challenging. Lack of appropriate community supports may require longer timelines to measure success and will, at a minimum, require significant alignment of resources to create access where it does not exist today.