



DEPARTMENT OF HEALTH
AND HOSPITALS

UPDATE ON LOUISIANA'S CONCEPT FOR MEDICAID MANAGED CARE FOR OLDER ADULTS AND PERSONS WITH ADULT ONSET DISABILITIES



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This paper provides an update on Louisiana's concept for Medicaid Managed Care for older adults and persons with adult onset disabilities. A separate paper will be provided that will focus on persons with Intellectual/Developmental Disabilities (ID/DD)

BACKGROUND

In February of 2014, DHH shared with stakeholders an updated concept paper that had been presented for discussion purposes to CMS. That paper indicated that the state was considering seeking CMS approval to implement Managed Long Term Supports and Services (MLTSS) under an 1115 Demonstration Waiver. Use of this federal mechanism tends to allow states broader leeway to implement and "demonstrate" the use innovative services, payment strategies, and different approaches to eligibility. But 1115 waivers also carry risks. Because programs approved under the 1115 authority must be cost-neutral according to federal rules, in order to expand eligibility or services states must project where they will achieve savings to fund any expansion. If these projections are wrong and the implementation is not cost-neutral, the state is required to reimburse federal funds.

After subsequent research and conversations with both CMS and experienced consultants, Louisiana has decided to adopt a two-stage strategy to implementing Medicaid Managed Care for older adults and people with adult onset disability.

The initial phase will be to transition programs and services **as they exist today** to a Managed Care delivery and payment system. In other words, there will be no addition of services to the Medicaid state plan, and no expansion of current eligibility. Existing LTSS programs will retain their current identities, such as Community Choices Waiver and LTPCS, with minimal changes to current program rules. This will allow for the least disruption of the service system and allow the state to gain experience in MLTSS delivery before pursuing more fundamental structural changes. It is also the best way to assure a

budget-neutral implementation for the state, and is the more encouraged approach from the perspective of federal authorities at CMS.

The second phase will be to use experience and data from the initial implementation of MLTSS to pursue more fundamental structural changes that might be beneficial, such as unbundling of services from programs; tiered LTSS benefit structure; introduction of innovative behavioral health services for non-SMI adults and persons with dementia; and expansion of eligibility for some minimal package of LTSS services to "at risk" populations who do not meet Nursing Facility Level of Care.

The advantages of the two-stage approach are as follows:

Provides for the greatest amount of stability in transition. Providers and recipients alike are familiar with the current programs, the available services within each program, service limits, program rules, and quality assurance requirements. These would by and large remain the same, though providers and recipients will have their payments and care coordinated through the MCOs.

Assures a budget neutral implementation for the state. Any addition or expansion of services or eligibility runs the risk of costing the state more. While managed care does have the potential to eventually lower the rate of spending growth through improved quality of care and by reducing expenses associated with unnecessary hospitalizations, readmissions, and non-emergent use of ERs, those savings can be hard to quantify without experience.

Eases implementation while reducing risk. Likewise, adding services for which there is no historical utilization data makes it difficult and problematic for actuaries to set the rates to be paid to MCOs. And CMS would require the state to quantify savings as part of any plan to expand populations or services. If for any reason these savings projections were not realized the state would be required to pay back the federal share of the excess spending.

Provides a base of experience to inform future change. MCOs will have broader flexibility and tools to address service gaps, incentivize desired outcomes, and improve quality of care than is available under Fee for Service (FFS). For the Aging/ Adult-Onset population, operating current programs under the managed care umbrella will allow plans, stakeholders, and the state to better quantify efficiencies and identify gaps that truly cannot be addressed without the more fundamental program redesign and structural changes possible under 1115 Demonstration authority.

Achieves most goals. Even without adding new services to Medicaid, Managed Care Organizations have tools that allow them to provide new, innovative, and cost-effective services to their members. DHH also believes that it will be possible to reduce waiver waiting lists, continue rebalancing, expand access to behavioral health services, improve health care outcomes, and expand use of consumer-directed services using the strategy outlined below for initial phase.

NUMBER OF PLANS

In keeping with stakeholder recommendations, Louisiana intends to contract with two to three MCOs to provide managed Medicaid services to older adults and persons with adult onset disabilities. All plans will be statewide.

BENEFIT DESIGN

As desired by stakeholders, MCOs will manage, coordinate, and pay for the full range of benefits to the MLTSS population of older adults and persons with adult onset disabilities. This will include:

- ▶ All Medicaid state plan services for acute and primary healthcare (e.g., doctors, hospitals, Durable Medical Equipment, hospice, etc.)
- ▶ Nursing Facility services
- ▶ Long Term Personal Care Services (LTPCS)
- ▶ Community Choices Waiver and Adult Day Health Care Waiver
- ▶ Behavioral Health Services – both regular state plan

and 1915(i) services for people with Serious Mental Illness

▶ Pharmacy

In other words, if you are a member of the MLTSS system for older adults and persons with adult-onset disabilities, all of your Medicaid services will be authorized and paid for by a single Managed Care Organization responsible for creating a coordinated plan that addresses all of your health, behavioral health, and long-term supports and service needs. The one small exception to this over-arching rule is that dentures for adults – which is the single dental service currently available to adults under Medicaid in Louisiana – will be managed and paid for under the current contract between DHH and MCNA Dental (Managed Care of North America).

Also, it is important to realize that while most people in MLTSS will have Medicare as well as Medicaid, DHH’s waiver and procurement only deal with Medicaid services. Members will continue to have the choice of how and where to receive their Medicare services. Dual-eligible members will have the ability to remain in their current Medicare Advantage (MA) Plan if they are enrolled in one, or to enroll in any MA Plan if they choose to do so.

How will there be more services?

Though new services will not be added to Medicaid, there are other ways that Managed Care plans can offer members more than what is available under the current FFS system. One of these mechanisms is referred to as “Value Added” services, which MCOs provide with no reimbursement from the state because the services are attractive to potential members, improve health, and/or can reduce healthcare costs. Some typical examples include things like preventive health screenings, dental, hearing, or vision goods and services unavailable under Medicaid; nutritional counseling; or incontinence supplies.

In addition to “Value Added” services, MCOs have some discretion to offer a lower cost service in place of a higher cost service if that is acceptable to the member and achieves a good health outcome. This is similar to the discretion that currently exists with PACE programs where, for instance, the MCO

can propose to treat a flea infestation to avoid medical costs associated with infected flea bites, or behavioral health intervention to avoid ER visits related to anxiety disorders and symptoms.

INCLUDED POPULATIONS

Populations to be included in MLTSS for older adults and people with disabilities include Medicaid recipients who acquire a disability at or after age 21, who meet eligibility for Nursing Facility Level of Care, and receive LTSS. This includes people receiving or approved for Community Choices Waiver, Adult Day Health Care waiver, and Long Term Personal Care Services (LTPCS).

It will also include **most** Medicaid recipients receiving or approved for care in a nursing facility. It is DHH's plan that short term nursing facility stays (e.g. post-acute or rehabilitation) would not by themselves trigger a recipient's enrollment in MLTSS.

The "pathways" into MLTSS can be summarized as follows:

- ▶ People receiving or approved for LTPCS
- ▶ People receiving or approved for Community Choices or Adult Day Health Care Waivers
- ▶ Medicaid recipients who are not in Bayou Health and are approved for a Medicaid-funded, long-term stay in a nursing facility

Regardless of the pathway, these individuals will have all of their Medicaid-funded care – whether it's physical health, behavioral health, or long-term supports and services – managed by a single MCO in the MLTSS system.

There is another important population that will be included in MLTSS for older adults and persons with adult-onset disabilities, namely individuals who receive health care benefits through both Medicare and Medicaid but who do not need any form of LTSS. This group is often referred to as "healthy duals," or "community-well duals." Because they are dually eligible for and receiving both Medicare and Medicaid, they are currently carved out of Bayou Health. DHH has made the decision to include this population in MLTSS for several reasons:

1. Most people who receive LTSS and who will be in the MLTSS system – roughly 80%

of all current LTSS recipients – are dually eligible. The MCOs contracted for MLTSS will, therefore, have to know how to coordinate Medicaid health care services for duals. That is, they will have to know how to improve healthcare outcomes and achieve program goals even though they are not managing the Medicare services for the majority of people they serve. This positions them to be able to do the same thing for "healthy" duals.

2. "Healthy duals" are at risk for needing LTSS eventually. Having responsibility for even the limited package of Medicaid services used by "healthy duals" allows plans to potentially identify and address risk for LTSS.
3. Inclusion of "healthy duals" in the procurement for MLTSS makes Louisiana's procurement more attractive to health plans because there are more "lives" to be covered. It also furthers the transition from legacy FFS Medicaid to a more accountable system of managed and coordinated care under Medicaid.

Excluded Populations

"Healthy duals" who have ID/DD will not be included in MLTSS for older adults and persons with adult-onset disability. People participating in PACE will also be excluded, as will individuals who only have their Medicare premiums paid by Medicaid.

PROVIDER NETWORK

MCOs will be required to contract with all LTSS providers in the initial year of implementation and individuals will continue to receive their LTSS services from the same provider unless they request a change. The rates that MCOs pay providers cannot be lower than the Medicaid FFS rate.

Louisiana will implement a single Electronic Visit Verification (EVV) system for personal care services prior to MLTSS Go Live. Implementing a single system that all MCOs will be required to use means that providers will not have to learn multiple EVV systems in order to generate and submit claims for personal care services.

For provider types and services that are not billed through the EVV, claim forms will be standardized across plans and plans will be required to maintain the same provider payment frequency and schedule as in current FFS Medicaid. A typical administrative performance measure in the world of Medicaid managed care is that “clean” claims submitted by providers must be paid timely by the MCO. Just as it does in Bayou Health, Louisiana will have stringent requirements for timely payment in MLTSS as well, and will measure plan performance in this area.

As the RFP is being developed, DHH is looking at ways to standardize the credentialing processes necessary for providers to contract with the MCOs. The RFP currently under development will include specific resource and performance expectations around initial provider outreach and training – especially to LTSS providers as a provider group new to managed care. All contracts will require ongoing provider assistance and complaint resolution, and DHH will monitor MCO performance around these functions. MCOs will be required to have an electronic system for tracking provider complaints and resolution.

MCOs will be required to have staff dedicated to provider training and technical assistance, both prior to implementation and on an ongoing basis. They will be required to have persons specifically tasked to working with providers of LTSS who have no prior experience with managed care.

CARE COORDINATION

Louisiana will require that all MLTSS members receive care coordination by the MCO. The state will require specialized case management for higher risk individuals including members receiving LTSS services in facilities or in the community, members with certain behavioral health needs, and members with certain chronic health conditions.

OTHER SYSTEM COMPONENTS

In keeping with feedback from stakeholders on the MLTSS Advisory Group, MCOs will not be responsible for determining if individuals are eligible for LTSS and participation in the MLTSS.

Instead, the state -- either directly or through an independent contractor -- will continue to use its current tools to assess and determine clinical/functional eligibility for LTSS, determine resource allocation for HCBS, and provide annual reassessment and recertification. The state will also provide assessment if a change in status is reported that could affect a member’s level of HCBS resource allocation. This removes the potential conflict of interest that exists when MCOs do the assessment that allows individuals to qualify for enrollment in the MCO. It also allows the state to continue independent collection of data that can be used for pre- and post-implementation quality measurement. This is because the MDS-HC, the tool used to establish eligibility and resource allocation for HCBS services, includes a risk adjusted set of 21 quality measures in domains related to pain management, nutrition, skin ulcers, falls, ADLS, depression, medication management, and hospitalizations. DHH has several years-worth of pre-implementation data to use as baseline in assessing the impact of MLTSS in these domains.

Independent enrollment brokerage will be through the same entity that performs this function for Bayou Health. This means that an unbiased third party will assist individuals in choosing an MCO. And because the same contractor will perform this function for both MLTSS and Bayou Health, they will be well-positioned to assist individuals who have to transition from one managed care system to the other.

In terms of participant protections, DHH intends to follow Advisory Group recommendations and contract with an independent Ombudsman rather than assigning this responsibility to MCOs as many states do. Louisiana will maintain a single Critical Incident reporting system that all MCOs in the MLTSS system will be required to use, and the state will monitor the timeliness and effectiveness with which MCOs handle critical incidents. Plans will be required to have grievance and appeal processes and will be held to tight timelines for resolving appeals. DHH will monitor these systems, and members will have access to an appeal process outside of the MCO if unsatisfied with the resolution.

QUALITY AND ACCOUNTABILITY

Despite differences in populations and included benefits, effort has been made to align quality strategy, monitoring, and measurement between Bayou Health, the Louisiana Behavioral Health Partnership, and MLTSS. All RFPs require plan accreditation. MCOs serving the MLTSS population will have to obtain NCQA accreditation as well as URAC accreditation for pharmacy benefits management. Bayou Health, the Louisiana Behavioral Health Partnership, and the MLTSS System will all use the same External Quality Review Organization (EQRO) to perform the external reviews that CMS requires for any Medicaid managed care program. What this means is that multiple entities – national accrediting organizations, EQRO, and DHH, will be looking at MCO readiness to go live, their ongoing organizational capacity, the accuracy with which MCOs report encounter data and quality measures, and how they actual perform on nationally benchmarked quality measures.

MCOs will be required to survey consumer satisfaction using the nationally certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the same survey currently used by Bayou Health. In addition to use of the CAHPS survey to assess satisfaction with acute and primary care, DHH will continue to use the Personal Experience Survey (PES), administered by an independent contractor, to assess experience and satisfaction with LTSS. As with the MDS, Louisiana has several years' worth of pre-implementation PES data that can be used as a baseline in assessing MCO performance. Louisiana has also been working

with CMS and its national contractors on a project to certify the PES as a CAHPS tool, which would facilitate across-state comparisons. Advisory Group members participating in the Quality and Outcomes workgroup expressed support for using these types of existing measures and tools that would allow comparison between pre-implementation and post-implementation performance, and expressed a preference for an independent survey of participant satisfaction with LTSS.

Louisiana will also establish measures, including “money measures,” and monitor plan performance in the following areas that were a high priority for stakeholders and Advisory Group members:

- 1. Rebalancing.** MCOs will be required to meet benchmarks for Money Follows the Person (MFP) and continue rebalancing at the same or better rate than is already being accomplished in the FFS system.
- 2. Consumer-direction.** With the implementation of MLTSS, Louisiana will expand self-direction to the LTPCS program. Plans will be given performance targets for increased use of consumer-directed services.
- 3. Improved health outcomes.** Louisiana will set expectations for improvements in such key areas as avoidable hospitalizations.

Finally, because Louisiana will be moving its existing HCBS waivers under the managed care umbrella, all of the federal quality assurance requirements associated with those waivers will remain in place.

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

*For additional information, please visit
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