



**A Response to the Louisiana Department of Health and Hospitals for the Louisiana LTSS Initial Program Concept Paper**

**Submitted by Amerigroup Louisiana, Inc.**

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## Table of Contents

<b>Introduction.....</b>	<b>5</b>
Louisiana’s LTSS Program Should Serve All Waiver Populations .....	5
Serving New Opportunities and Residential Options Waiver Populations .....	6
Serving the Community Choices Waiver Population .....	8
Serving the Supports Waiver Population .....	9
Serving the Adult Day Health Care Waiver Population.....	9
Serving the Children’s Choice Waiver Population .....	9
Serving the Needs of Children with Serious Emotional Disturbances .....	11
Amerigroup: The Ideal Partner for the Bayou State .....	11
<b>Incorporating CMS Key Principles .....</b>	<b>13</b>
Adequate Planning and Transition Strategies.....	13
Consumer/Stakeholder Engagement.....	14
Consumer Independence.....	15
Ability to Change MCOs for Cause .....	15
Comprehensive and Integrated Service Packages.....	15
Alignment of Payment Structures with Program Goals.....	16
Qualified Providers.....	16
Protection from Abuse, Neglect and Exploitation .....	17
Appeals and Grievances.....	18
Quality.....	18
Administrative Lock-In .....	18
<b>Populations .....</b>	<b>20</b>
<b>Enrollment.....</b>	<b>21</b>
Amerigroup Recommends: Mandatory Enrollment .....	21
Getting Members and Stakeholders Involved .....	21
<b>Benefit Design .....</b>	<b>23</b>
Focusing on the Member.....	23

<b>Coordination with Medicare .....</b>	<b>25</b>
Federal Assistance through My Place Louisiana .....	25
Provider Network Adequacy Standards .....	26
<b>Focus on Rebalancing .....</b>	<b>27</b>
Care Coordination Approach .....	27
Transitioning Institutionalized Members .....	28
Plan Principles for Self-Directed Care .....	28
Culture of Quality .....	28
Supporting Integrated Care through Technology .....	28
Fully integrating Disease Management .....	29
Linkage with Local Agencies for Services and Supports .....	29
<b>Consumer Protections .....</b>	<b>30</b>
Choice and Consumer Supports for Self-Directed Care .....	30
Corrective Action for Untimely Access .....	31
Call Centers Representatives and Member Advocates .....	31
Cultural Competency .....	31
Continuity of Care .....	32
Protection from Abuse, Neglect and Exploitation .....	32
Appeals and Grievances .....	32
<b>Providers .....</b>	<b>33</b>
Enhancing Existing Provider Networks to Ensure MLTSS Network Adequacy .....	33
Reimbursement and Claims Practices .....	33
Continuity of Care .....	34
Specialized Provider Relations Support .....	34
Educating Providers in Transitioning from FFS to MLTSS .....	35
Prior Authorizations .....	35
<b>Choosing Your MCO Partners .....</b>	<b>36</b>
1. Demonstrated Experience in Coordinating Services within LTSS .....	36
2. Experience Coordinating Services for Dual Eligibles .....	36

3. Experience Assembling an LTSS Provider Network.....	36
4. Cultural Competency .....	37
5. Integrated Behavioral Health Capabilities .....	37
6. Stakeholder Engagement.....	38
7. Efficiencies in Administration .....	38
8. Quality Management .....	38
9. Accountability .....	38
<b>Service Coordination.....</b>	<b>40</b>
Designing Optimal Service Coordination .....	40
<b>Measuring Quality and Outcomes.....</b>	<b>42</b>
Ongoing Stakeholder Involvement .....	43
<b>Accountability.....</b>	<b>44</b>
Accountability through a Capitated Rate and Incentives Payment Structure .....	44
<b>Implementation .....</b>	<b>46</b>
Recommended Implementation Rollout .....	46
Partnering with Stakeholders .....	47
Building a Sufficient Provider Network.....	47
Providing Recipient Information to Participating MCOs.....	49
<b>Conclusion .....</b>	<b>50</b>

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## INTRODUCTION

### Louisiana's LTSS Program Should Serve All Waiver Populations

Incorporating the existing subpopulations currently participating in each of Louisiana's waiver programs and those participating in the Louisiana Money Follows the Person program, My Place Louisiana, will enable DHH to consolidate its administration of programs, avoid fragmentation of state resources and services, and achieve new budget savings. It will also facilitate continuity of care for individuals who might otherwise have to pursue care and services across multiple programs.

Managed Care Organizations (MCOs) serving the populations accessing the various waiver services that DHH administers should have the following core competencies and components:

**Placing Members at the Center of their Care and Supports.** Self-direction, responsibility, and independence should be emphasized with customized approaches to care and services. DHH should include services within the managed long-term services and supports (MLTSS) program that allow and encourage self-direction to the fullest extent and with the broadest range of services possible. Members should be empowered and encouraged to be active, leading participants in their care in a way that fosters independence and quality of life.

**Supporting Early and Effective Stakeholder Engagement and Ongoing Collaboration.** MCOs participating in MLTSS must thoroughly understand the existing LTSS environment and waiver programs to assess what is working effectively and what opportunities for improvement exist. They should be identifying, frequently meeting, and partnering with trusted stakeholders, such as Area Agencies on Aging and Disability (AAAD), local ARCs and Louisiana AARP, and potential providers and associations to facilitate smooth member and provider transitions into MLTSS. Early engagement with key stakeholders creates collaborative partnerships and establishes trust, resulting in better outcomes for our members while addressing the needs of the providers themselves.

**Providing Specialized Provider Support.** The relationship between MLTSS members and their providers is critical and has a distinct impact on the outcome of member care. MCOs should be prepared to focus on identifying existing providers serving LTSS members and engaging them early to build collaborative, trusting, and supportive relationships. They should have experienced provider relations staff who specialize in serving the LTSS provider community and are entrenched in the community. This is especially true in Louisiana where the diverse cultures and practices vary by parish and each community is unique. Education and communication will be critical as many LTSS providers may be new to the Managed Medicaid

program broadly and MLTSS specifically. Immediately before, and for the first year following the implementation of the new MLTSS program, MCOs should have provider training materials that address provider questions, as well as face-to-face, webinar, and telephone training based on providers' needs.

**Understanding Cultural and Regional Disparities.** Participating MCOs must be prepared to accommodate and address issues associated with underserved communities, remote geographic location, housing challenges and other community dynamics that contribute to the uniqueness of each member's needs. Most importantly, they must have the cultural competency to respond appropriately and effectively to the wide range of cultural diversity that exists within Louisiana's borders.

## Serving New Opportunities and Residential Options Waiver Populations

The New Opportunities Waiver (NOW) focuses on member self-determination in providing its more than 8,500 members with developmental disabilities, including persons with intellectual disabilities, needing an ICF/DD level of care with supplemental family and/or community supports that support dignity and quality of life. Services are developed using a person-centered process, coordinated by a case manager who works with the member in formulating an individualized care and service plan. NOW services supplemental to State Plan services including residential support, respite, community integration and development, work-related supports, habilitation, environmental modifications and specialized equipment, and professional services. NOW is so popular with Medicaid enrollees that at least 10,000 additional individuals are on a waiting list seeking entry.

Residential Options has the capacity to offer as many as 265 individuals of all ages services designed to support them in transitioning from intermediate care facilities for the developmentally disabled (ICFs/DD) and nursing facilities to home- and community-based settings. The services offered include support coordination, community living supports, host home services, companion care services, shared living, respite care, personal emergency response systems, transition services home modifications, assistive technology, specialized medical equipment and supplies, transportation access, supported employment, pre-vocational services, day habilitation, and professional, nursing, and dental services.

Although the services offered are robust, the program currently has only 26 enrollees. Whether this low enrollment is due to the structure of the program, limited state revenues, or the limited availability of accessible housing options within the state, inclusion of the Residential Options members to a more comprehensive MLTSS program should afford them more ready access to the comprehensive services they seek at a lesser cost to the state.

## Serving Persons with Developmental Disabilities in the New Opportunities and Residential Options Waiver Programs

In serving New Opportunities and Residential Options members, the Louisiana MLTSS program should be member-centric and integrated. Participating MCOs should be able to support comprehensive delivery of the following services to members with intellectual and/or developmental disabilities.

**Self-Direction.** Recognizing the importance of self-determination for members with disabilities, any MLTSS program implemented to replace the existing waiver programs should maximize each member's involvement in the development of his or her care and service plan and in selecting, hiring, and directing caregivers and services. Where the individual has an appointed guardian or individual granted the power of attorney, that individual should be engaged in the development of the model of care and in caregiver selection and direction. We encourage DHH to include services within the MLTSS program that allow and encourage self-direction to the fullest extent and with the broadest range of services.

**Accessible Housing.** The Louisiana MLTSS program should operate under the basic principle that services for persons with development disabilities can be most cost-effectively provided, and are preferred, in each member's familiar community environment rather than within the walls of an institution. When care and services are provided outside of an institutional setting, a greater number of individuals can be served more cost-effectively and the state's capacity to serve individuals is greatly increased. A home- and community-based approach also affords the best outcomes. Individual receive services in their homes tailored to their preferences and specific needs and coordinated with recognition of their home and community environments and family circumstances.

**Provider Access and Family Caregiver Supports.** The Louisiana MLTSS program should recognize the importance of a strong, diverse, culturally competent provider network to deliver both medical and non-medical care, supports, and services. In some circumstances, it will not always be possible for the member—particularly one residing in a remote area—to travel to a provider. So, in remote areas, individuals should be provided assistance with public transportation, or providers should be incented to visit the home. DHH should also strongly consider the effective use of telehealth, particularly for behavioral health services.

Families often undergo significant physical and psychological stress in supporting the needs of a person with a disability. For that reason, Amerigroup Louisiana, Inc. (Amerigroup) encourages DHH to include well-resourced respite services in the program benefits to enable those family members to maintain their health and well-being so they can then meet the needs of the member with renewed strength and resolve.

**Integrated Employment.** When persons with developmental disabilities are employed, their individual success and employment contributions can improve the odds for better health outcomes. For this to occur, systems must be developed and incentives introduced to support the encouragement of post-secondary education and competitive, integrated employment. With these systems in place, Louisiana expenditures associated with subsidized sheltered workshops can be reduced and reallocated as the member becomes a taxpayer contributing to state revenues.

## Serving the Community Choices Waiver Population

DHH should include in the MLTSS program the 4,300 adults with disabilities and aging adults needing a nursing facility level of care who are currently enrolled in the Community Choices Waiver program. Doing so will give enrollees access to community resources so they can maintain their independence and, if they prefer, direct their own care in a cost-effective way, a win-win for both the enrollees and DHH.

Community Choices services presently include support coordination (case management), transition intensive support coordination and other transition services for individuals moving out of nursing homes, personal assistance services, assistance with activities of daily living (ADLs), Adult Day Health Care Service (health/medical and social services provided in a community-based center), home modifications to aid in self-care, assistive devices and medical supplies, nursing services, home-delivered meal services, respite for family caregivers, housing stabilization services, and housing transition and crisis services, as well as physical, occupational and speech therapies. DHH should include these services as covered benefits in the MLTSS program.

## How the MLTSS Program Can Serve Community Choices Program Members

In the new Louisiana MLTSS program, MCO care coordinators should assess members residing in nursing facilities at the time of enrollment and periodically thereafter to determine the member's interest in transitioning to the community and the support and services needed for the member to do so. Members residing in nursing facilities can also be identified through referral from nurse practitioners, nursing facility staff, providers, family members, or community-based organizations. Transition plans should identify specific home health and/or adult day services, medication, and equipment, and arrange for appropriate home modifications and transportation. The member, family, and caregivers should be informed about available community resources and federally funded programs such as the state Money Follows the Person program, My Place Louisiana.

Following member discharge from the nursing facility, the care coordinator should maintain close contact with the member, family, and/or caregiver to verify the member is receiving those services and supports and that transition is smooth.

In addition, DHH should continue to provide home modifications for individuals moving from the Community Choices program to a MLTSS program. Such assistance should include at least installing assistive devices and ensuring access, such as through the widening of doors.

As noted previously, respite enables family caregivers to meet the needs of their family members while maintaining their health and well-being. For that reason, Amerigroup encourages DHH to continue to include respite services for family caregivers of members in the MLTSS program.

## Serving the Supports Waiver Population

DHH should include the almost 2,200 Louisianans currently enrolled in the Louisiana Supports Waiver program in the MLTSS program. Under the Supports Waiver, Office for Citizens with Developmental Disabilities (OCDD) offers direct waiver payments for focused, individualized vocational services to Louisianans age 18 and older who otherwise would require the level of care of an ICF/DD. The services for which payments may be made include support coordination, supported employment, day habilitation, pre-vocational and habilitation services, respite care for family caregivers, and the use of a personal emergency response system. These benefits should be continued as covered benefits under the MLTSS program.

Because meaningful employment produces positive emotional, behavioral, and physical health consequences, the Supports Waiver program tends to improve the overall health status and well-being of its members. The MLTSS program should offer employment specialists who are trained and experienced in supporting employment efforts and who can assist in obtaining meaningful and lasting employment.

## Serving the Adult Day Health Care Waiver Population

Amerigroup recommends that DHH include in the MLTSS program the more than 700 seniors and adults age 22 and over with physical, intellectual, and functional impairments who need a nursing facility level of care, currently being served through the Louisiana Adult Day Health Care program. We believe adult day services are essential to maintaining optimal and social functioning for members living in their homes and their community.

## Serving the Children's Choice Waiver Population

Amerigroup believes the Louisiana MLTSS program would make a real difference in the lives of the more than 1,200 children with developmental disabilities who meet the medical and

psychological criteria for an ICF/DD level of care and participate in OCDD's Children's Choice program, as well as a difference in the lives of their family members. Children's Choice currently provides support coordination/case management, family support and center-based respite, home modifications, and family training. It is our understanding that this waiver would expand in the future to provide specialized medical equipment and supplies, applied behavioral analysis based therapy, aquatic therapy, art therapy, music therapy, sensory integration, and hippo therapy/therapeutic horseback riding.

The Louisiana MLTSS program should take an innovative, self-directed, and person-centric approach to providing coordinated services that address the unique physical, behavioral, social, functional, and environmental needs of each child or youth and their families. The entity responsible for following each child's treatment plan, ongoing service coordination, timely access to specialty providers, and program evaluation should:

- Work with families to support children in leading independent and healthy lives;
- Facilitate coordination of personalized, comprehensive long-term services and supports and services that support children in thriving at home with their families;
- Provide member-guided services through self-directed options;
- help caregivers and family members support the child;
- Designate a single point of contact to help members and family navigate an often complex health care system;
- Identify all care and service needs early, thus preventing acute conditions and hospitalizations; and
- Act to assist members and families in maintaining access to both primary care providers (PCPs) and specialty physicians as needed.

In addition, the personal caregivers of children with disabilities are a core foundation of the family structure and a valuable resource within each child's system of natural supports. But they can only provide support if they are, in turn, offered the assistance they may need to strengthen their efforts. For that reason, the MLTSS program should be prepared to help parents and siblings to access respite services so they can then meet the needs of their family members.

## Serving the Needs of Children with Serious Emotional Disturbances

Louisiana has received waiver approval from CMS for a program supporting as many as 1,200 children diagnosed with serious emotional disturbances (SEDs). The program would provide crisis stabilization, independent living skills building, parent support and training, short-term respite, and youth support and training. The Louisiana MLTSS program should be prepared to implement these additional services in a robust but economical manner.

Because many members with SED have comorbid medical and behavioral conditions, the Louisiana MLTSS program should have an integrated care management strategy that addresses all member needs, including medical, behavioral, social, functional, and environmental needs. The whole-person care management approach taken by MCOs works with providers to develop treatment plans through all phases of the individual's condition(s) and works with and educates members and their families to self-manage their conditions and enhance function. This approach should include finding resources and supports in the community and referring for appropriate wellness services once condition and behaviors have stabilized.

Community Mental Health Centers (CMHCs) are a vital component of any provider network. Participating MLTSS plans should work with the existing community-based providers on the ground, including schools, CMHCs, Rural Health Centers (RHCs), and Federally Qualified Health Centers (FQHCs), supplementing those existing provider resources with individual practitioners when necessary to ensure adequate access. Where existing community providers have a traditional responsibility for providing services, they should be contracted to continue to do so.

## Amerigroup: The Ideal Partner for the Bayou State

Amerigroup applauds the Department of Health and Hospitals' (DHHs') commitment to a more integrated, robust, and comprehensive (MLTSS) program that rebalances services between institutional and community settings, provides meaningful access to necessary providers and offers a full array of preventive services. Amerigroup agrees with DHH that a comprehensive managed long-term services and supports (LTSS) program will reduce care fragmentation through improved coordination and provide greater independence through a wider selection of home- and community-based living options for members and their families. We look forward to being part of this process and to working collaboratively with DHH—as well as the OCDD, the Office of Aging and Adult Services (OAAS), Louisiana Rehabilitation Services and the Louisiana Developmental Disabilities Council (LaDDC), and legislators,

advocates, stakeholders, and trusted local community providers—in effecting the systems change that will bring comprehensive and quality robust care and services to Louisiana persons with disabilities and aging adults.

Amerigroup welcomes the opportunity to collaborate with the DHH in meeting the state’s goal of achieving full community integration through the MLTSS program. We already work with the state in serving more than 128,500 members statewide through the Louisiana Medicaid, Children’s Health Insurance (CHIP), Pregnant Women, and Supplemental Security Income/Aged, Blind and Disabled (SSI/ABD) programs. We now stand equally ready to share our experience to help the state serve the almost 17,000 members enrolled in the services of the New Opportunities, Supports, Residential Options, Community Choices, Adult Day Health Care, Children’s Choice, and Coordinated Serious Emotional Disturbances in Children waiver programs, as well as the thousands more currently on program waiting lists.

Across the country, WellPoint, Amerigroup’s parent organization, is a leader in Medicaid and MLTSS program management. Our affiliates currently coordinate MLTSS for approximately 140,000 aging adults and adults with disabilities in eight states: California, Florida, Kansas, New Jersey, New Mexico, New York, Tennessee, and Texas. In 2014, we will be providing MLTSS in Virginia as well. Our programs support participants with holistic care and services, independent living supports in the community, and self-direction of care and services, driving positive health outcomes and savings for the Medicaid programs in which they are enrolled. We work hand-in-hand with our state partners to help see that individuals enrolled in Medicaid managed care have access to the most robust set of LTSS possible. We are positioned to do the same in Louisiana.

## INCORPORATING CMS KEY PRINCIPLES

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

Fundamental to effectively applying the principles set forth by CMS in its May 2013 MLTSS guidance to the states is the selection of MCOs that understand the complex medical, functional, and behavioral health needs of individuals who participate in MLTSS programs.

Any MCO selected to participate in DHH's rebalancing effort should be experienced in addressing the needs of aging adults and persons with disabilities in a holistic manner, including an understanding of the social and economic challenges that can unfavorably impact their ability to live in their community and on their own terms. A participating MCO must not only have the personnel skilled in holistically addressing the needs and interests of these populations, their families and caregivers, providers, and community supports, but also the infrastructure related to care management processes, benefit design, technical process, and provider network development.

Amerigroup shares CMS's vision relating to plan responsibilities, particularly those principles focused on adequate planning and transition strategies, stakeholder engagement, the enhanced provision of Home and Community-Based Services (HCBS), person-centered processes, comprehensive and integrated service packages, qualified providers, participant protections, and quality. Adherence to CMS' principles will help achieve great gains in health and community living outcomes while ensuring a cost-effective, synergistic expenditure of state funds.

### Adequate Planning and Transition Strategies

As CMS suggested in its MLTSS guidance, the transition to MLTSS requires that there be a comprehensive planning process, under an aggressive timeline that is still sufficient to educate providers and participants in the demands and rewards of the MLTSS system while guaranteeing outreach to and input from stakeholders, including consumers, families, MCOs, and providers. DHH has demonstrated commitment to this requirement and is to be commended for its ongoing stakeholder engagement.

Transitioning to MLTSS in Louisiana will require the involvement of a number of state leaders beyond the Medicaid agency, OAAS, and OCDD, including the Governor's Offices of Disability Affairs and Elderly Affairs, Louisiana Rehabilitation Services, and the LaDDC as well as interested legislators. The state should be transparent in its expectations regarding the MLTSS program and its expectations of the participating MCO plans. Clear benchmarks should be negotiated and set. Where those benchmarks are expected to progress over the

duration of the program, they should be transparently negotiated and communicated up front. The methodology for calculating and setting actuarially sound plan capitation rates also should be transparently communicated between the parties prior to launch and during each year of the program so there are no surprises in later years that might result in a disruption of continuity of care for members.

Amerigroup agrees with CMS that there should be a transition period for moving between fee-for-Service (FFS) LTSS and MLTSS, under an aggressive timeline that facilitates continuity of care by accommodating participation by a beneficiary's existing provider, for a period of no more than 90 days. This transition should last until the provider is able to contract with the participating plan's network, the beneficiary is able to find a network provider with which he or she is comfortable, or the beneficiary's health care assessment and personal care plan suggest the need for another provider. Out-of-network providers accommodated through this process should be reimbursed at Medicaid FFS reimbursement rates. In at least the initial years of the MLTSS program, providers who contract with any MCO should be mandated to contract with all participating MCOs to avoid barriers to continuity of care.

## Consumer/Stakeholder Engagement

Incorporating all stakeholders, including members, providers, and advocacy groups of all LTSS populations, can provide the state significant insight in planning, implementation, and ongoing oversight of the MLTSS program. Stakeholder engagement and collaboration are critical components that help ensure a smooth, efficient transition to managed care. State and MCO stakeholder advisory groups, provider and member educational tours, multiple educational mailings, transparency in design, and oversight through the Web posting of materials are all good examples of ways the state can meaningfully engage stakeholders. Ongoing stakeholder involvement after implementation is also crucial to obtaining critical feedback for program improvements.

The MCO selected should have demonstrated, long-standing relationships with national and local advocacy organizations representing aging adults and persons with disabilities. Ongoing engagement with Louisiana-based stakeholder and advocacy organizations will be crucial to the program's success and to keeping constituents informed, involved, and engaged in the process. DHH and participating MCOs may find it appropriate to contract with some of these groups for assistance with community outreach and educational efforts.

## Consumer Independence

Critical components of any person-centered coordination of benefits should include: (1) meaningful choices of services and service providers; (2) holistic care plans based on early comprehensive needs assessments, which include goals meaningful to the member; and (3) the opportunity to self-direct services with appropriate supports. An approach supporting consumer independence also leads to a more efficient, effective use of taxpayer dollars.

The Louisiana MLTSS program should adhere to a person-centered approach designed to meet members' needs and preferences that supports them in having the quality of life and level of independence they wish to achieve. The member (and his or her designee) should be an active participant and leader in the service planning and delivery processes with the opportunity and supports to self-direct their care and services.

For a member returning to the community, the participating MCO should be fully engaged even prior to the time of that return in supporting the member in identifying and accessing the community resources that he or she will need to live independently.

## Ability to Change MCOs for Cause

Where DHH determines that a member is unable to access the care and services needed and promised, services are consistently being delivered in an untimely manner, or the MCO's appeals and grievance processes are determined to be unresponsive, the member should be allowed to change MCOs.

## Comprehensive and Integrated Service Packages

DHH should ensure that all covered and appropriate physical health, behavioral health, and pharmacy benefits are covered by each participating managed care plan in addition to the home- and community-based services and supports offered through the existing waivers and subsumed into the overall MLTSS program. No benefits should be carved out; benefit carve-outs impede an individual's right to seamless and integrated care and services and interfere with the MCO's ability to coordinate care and services and effectively review and improve health outcomes. When all covered services are included through the managed care program, participating MCOs can fully optimize their value to the state and to members.

Meeting members' medical and non-medical needs and providing them access to the quality of life and level of independence they desire within the MLTSS program starts with person-centered processes. Active participation by the beneficiary or his/her designee in the service planning and delivery process is a critical component that DHH should expect to see reflected in MCO applications for participation.

## Alignment of Payment Structures with Program Goals

Aligning payment structures with MLTSS program goals supports a diverse, quality provider network, improves the health of populations and the beneficiary experience of care, and reduces costs. MCO capitation rates must be actuarially sound and sufficient to encourage the delivery of high-quality services in home- and community-based settings and support the goal of community integration.

Effectively incorporating and maintaining the CMS key principles requires a rate structure that is transparent and collaborative between the contracted parties (e.g., the plan and the state), to establish a relationship based on trust with participating MCOs. If the participating MCO is a full partner with the state, it will be incented to actively search out and recommend program upgrades to further strengthen the MLTSS program in an ongoing manner.

Capitated rates for each of the eligibility groups must be actuarially sound, based on a blend of the anticipated mix of clients living in nursing facilities and in the community. Rate structures should address any existing imbalance between nursing facilities and home- and community-based services. Rate cells for duplicative or unnecessary services should be eliminated.

Rates should be structured to cover projected service costs, administrative costs, and operating margin in order to properly incent health plans to slow the rate of institutionalization over the long term. During the initial years of the shift to the MLTSS program, rates should be subject to meaningful risk corridors to protect participating MCOs from extraordinary and unexpected costs and to protect the state from unexpected losses. Rates also need to incorporate the costs of the new federal health insurance tax on Medicaid managed care plans as well as the lost tax deductibility. Finally, rates should specifically reward effective coordination of care in order to improve post-acute care in the home and community and ensure coordination between medical physical care, behavioral health care, and social services.

An actuarially sound premium should be based on the benefits and services provided, quality outcomes measured, the populations covered, the providers necessary to deliver the benefits and services, the service coordination model utilized, and provider reimbursement parameters. There should be an ongoing state evaluation of actuarial soundness. The state should actively engage the MCOs in the rate development process to maximize transparency and to provide opportunities for MCOs to provide input based on their first-hand expertise.

## Qualified Providers

While current credentialing and network adequacy systems have been developed based on an acute and primary care service delivery model, CMS expects states to assure that managed care networks also meet the needs of MLTSS members, including adequate capacity and expertise

to provide services that support community living—including transportation, housing, and employment supports—and the provision of training and technical assistance to providers.

Network adequacy standards should be appropriate to the specific services expected to be delivered, geographic areas, and populations covered by the program. This includes geographically appropriate standards for access to services, provider certification requirements and training, and technical assistance for providers. Plans should also have some degree of flexibility in designing networks that effectively address care gaps.

Participating plans should have a demonstrated track record of engaging with MLTSS providers and understanding the unique needs of these types of providers. This includes having educational tools, claim submission capabilities tailored to MLTSS providers, and provider relationship management programs to provide on-going hands on support.

Finally, the state can help to safeguard network adequacy and continuity of care, especially in remote rural areas, by requiring that providers contracting with any one MCO contract with all MCOs and—at least in the program’s transition years—that all providers be reimbursed for MLTSS services at the Medicaid FFS rate. Further, the state should review and approve model contracts offered by the MCOs to assure that providers are not incented to limit participation to one or fewer than all MCOs through the first year.

## Protection from Abuse, Neglect and Exploitation

In a 2009 phone survey sponsored by the National Institute of Justice of 5,777 individuals age 60 years and above, 11 percent of the respondents reported at least one form of emotional, physical, or sexual abuse in the previous year. It is estimated that for every one case of elder abuse, neglect, exploitation, or self-neglect reported to authorities, about five more go unreported.<sup>1</sup>

Research indicates that older victims of even modest forms of abuse have dramatically (300 percent) higher morbidity and mortality rates than non-abused older people.<sup>2</sup> Various studies have demonstrated that older adults who are victims of violence have more health care problems than other older adults, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems.

These are just some of the vulnerabilities that underscore the importance of robust health and welfare safeguards, protections, and monitoring in the transition to MLTSS and ongoing operation of the program. DHH should ask MCOs to address this vulnerability through program design and a strong critical incident management system. Participating MCOs must be

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<sup>1</sup> National Center on Elder Abuse (1998), National Elder Abuse Incidence Study.

<sup>2</sup> Lachs, M.S., Williams, C.S., O'Brien, S., Pillemer, K.A., & Charlson, M.E. (1998). "The Mortality of Elder Mistreatment." JAMA. 280: 428-432.

mandated to monitor, detect, and remediate in a timely and effective manner abuse, neglect, and exploitation.

DHH should also establish a statewide MLTSS ombudsperson specifically designated to provide support and remediation for issues not addressed through MCO appeals and grievance processes or the state fair hearing process. In addition, MCO representatives should work with the existing statewide ombudspersons on a regular basis to address critical incidences and grievances and ensure internal practices are up-to-date and meet state law standards.

## Appeals and Grievances

If the Louisiana MLTSS program is to effectively serve dual-eligible enrollees, utilizing Medicare and Medicaid funding, we would recommend that DHH integrate the Medicaid and Medicare grievance and appeals processes to the extent permitted by the state and CMS. To the extent possible, appeals' and grievances' processes should be largely based on the Medicaid process with which most members are familiar. However they are structured, appeals and grievance processes must be timely and fair; benefits should be continued until a full resolution of the member's grievance or appeal is reached.

We would also reiterate our recommendation, stated above, that DHH establish a statewide MLTSS ombudsperson specifically designated to provide support and remediation not addressed through MCO appeals' and grievances' processes or the state fair hearing process.

## Quality

Quality performance measures utilized by the Louisiana MLTSS program should include Healthcare Effectiveness Data and Information Set (HEDIS) and non-HEDIS measures as well as Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results. DHH should consider developing additional indicators with its participating MCOs that include measuring ER utilization, community reintegration, and meaningful employment in the community.

## Administrative Lock-In

MCOs should have experience in detecting and deterring member diversion or the knowing or unknowing of inappropriate use of services. Administrative lock-in programs, in which identified beneficiaries are restricted to particular providers for an extended period of time, can be highly effective in controlling those situations. Participating MCOs should be able to initiate lock-in programs for members who are persistently noncompliant, demonstrate abusive or threatening conduct, commit fraud or abuse of benefits, or utilize services at a frequency or amount not medically necessary. MCOs should be able to identify members who exhibit these aberrant behaviors by routine, comprehensive data reviews, and referrals.

Lock-in programs protect members by seeing that they get the services and quality of care they need. Participating MCOs should be experienced in operating lock-in programs for pharmacy, PCPs, physician groups, nurse practitioners, clinics, durable medical equipment suppliers, dental, behavioral health, podiatry, and hospitals.

## POPULATIONS

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

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

To best serve their diverse needs, Amerigroup recommends requesting approval from CMS for the merger of the state's existing §1915(c) waivers into a single § 1115 waiver incorporating the New Opportunities, Supports, Residential Options, Community Choices, Adult Day Health Care, Children's Choice, and Coordinated Serious Emotional Disturbances in Children waiver programs. A single program procurement would minimize fragmentation in infrastructure and service delivery and equip providers to better serve the comprehensive needs of members and maintain continuity of care by avoiding multiple transitions across programs.

Amerigroup recommends a track for implementation parallel to that taken to implement the Bayou Health three-part geographic rollout in 2012. Following this formula, the three-part rollout would begin with General Service Area (GSA) A Regions 9 and 1, followed by GSA B regions 2, 3, and 4, and concluding with GSA C Regions 5 through 8. We also recommend that DHH avoid any disconnect in enrollee services and a fragmented approach by creating a holistic rollout of services in each region. Any attempt to stagger either enrollees by service needs or populations would only create confusion.

## ENROLLMENT

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

### Amerigroup Recommends: Mandatory Enrollment

In order to create a program that best addresses the needs of the members while being efficient and cost-effective, we recommend that both the Medicaid-only and dual-eligible populations be served with LTSS under a full-risk, mandatory enrollment. The success of integrated care plan demonstration depends in large part, on maximizing enrollment as quickly as possible, and mandatory enrollment is the most workable approach for achieving this. Reaching a rapid critical mass in enrollment quickly is necessary for four reasons:

- **Savings:** Rapid scaling up is essential to producing near-term savings for the Medicaid program from better service coordination, preventive services, and diversion from institutional settings to community-based services.
- **Infrastructure:** High-volume enrollment is essential so health plans can invest in the infrastructure necessary to support the full spectrum of benefits and a robust service coordination function, and also be able to exercise sufficient buying power in the marketplace to control costs and ensure a broad provider network.
- **Equitable Distribution of Enrollees:** Mandatory enrollment is necessary to ensure the highest need members are distributed equitably across health plans.
- **Evaluation:** Large-scale participation is necessary so there can be a meaningful evaluation of the approach in the early stages of implementation and quickly later, as needed.

### Getting Members and Stakeholders Involved

Even prior to the enrollment process being launched, incorporating the insight of all stakeholders—including members, families, providers, and advocacy groups representing populations and providers impacted by the implementation of MLTSS—helps to access information instrumental for the state’s planning and implementation process and continued stakeholder engagement and collaboration.

## Education and Outreach

A strong education and outreach plan is critical to the successful initial rollout of an integrated program for members receiving MLTSS. DHH, with support from participating MCOs and advocacy organizations, should organize informational and enrollment events at all levels, as well as multiple educational mailings and forums for enrollees to learn about the program, their health plan choices, and how the enrollment process will work. Meaningful engagement can also be facilitated through provider and beneficiary tours, local media, on-line Web-based information, direct mail, and consultation and outreach contracts with advocacy groups such as those listed in *Consumer/Stakeholder Engagement*, on page 14.

Outreach should also include grassroots efforts. In each parish in the program service area(s), DHH should hold town hall meetings to educate interested stakeholders and explain how the program will work and present the agency's vision for the program. Stakeholders should be able to ask questions and get answers from agency officials and participating MCOs.

All available local media should be enlisted to promote the details of the program in all pertinent languages and be fully accessible to those with disabilities. A multi-channel approach will help ensure that information reaches individuals with limited access to transportation and/or technology. Additional emphasis should be placed on scheduling provider meetings to educate the provider groups, including doctors, hospitals, home health providers, nursing facilities, and community- and faith-based LTSS providers. DHH should also incorporate into its outreach any best practices derived from experience with previous state waiver programs. This outreach effort also should afford an opportunity to fully engage nursing facility providers, working with them as resource partners. This will help to create a sturdy, long-term, collaborative investment in a program that is fiscally sustainable.

## Ongoing Stakeholder Involvement

Stakeholder meetings should continue at least throughout the first year of the MLTSS program to ensure ongoing communications and provide stakeholders and interested parties an opportunity to provide feedback. Both are important to the program's long-term success.

## BENEFIT DESIGN

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

Amerigroup recommends a full-risk managed care delivery model for Louisiana's MLTSS program, with a comprehensive set of services that span acute care, institutional, home- and community-based, pharmacy, and behavioral health services, with comprehensive care and disease management programs across all services. Under this model, MCOs will be able to deliver a broader range of services and ensure robust member utilization, while facilitating opportunities for members to thrive in the settings of their choice.

MCOs have incentives to deliver care and services most efficiently by establishing a single, more flexible care and service plan that reflects each member's full array of services and preferences. A full-risk, fully integrated managed care delivery model gives MCOs the flexibility to tailor care and service plans to the member's needs and preferences, better coordinate services, and ensure network adequacy. It also affords members a greater ability to receive individualized care plans and results in increased efficiencies, self-direction, individual safety, and improved health outcomes.

### Focusing on the Member

The MLTSS program should require that MCOs offer a person-centered approach to service coordination, involving the member in the service planning process so that they are guiding their services and their needs are met in a holistic, timely and uninterrupted manner, without duplication. The critical components of person-centered service coordination are listed at *Consumer Independence*, page 15.

To address the comprehensive needs of LTSS members, Amerigroup recommends that DHH include the services in Table 1 on the following page.

*Table 1. A Blend of Acute Services and Long-Term Services and Supports is Recommended*

Acute Health Services	Long-Term Services and Supports	Other
<ul style="list-style-type: none"> <li>▪ Hospital inpatient/outpatient</li> <li>▪ Behavioral health inpatient/outpatient</li> <li>▪ Skilled nursing</li> <li>▪ Rehab therapies (including physical, occupational, speech/language)</li> <li>▪ Outpatient diagnostic</li> <li>▪ Laboratory</li> <li>▪ Professional services</li> <li>▪ Ambulance</li> <li>▪ Emergency room</li> <li>▪ Home health</li> <li>▪ Hospice (through FFS)</li> <li>▪ Transplant services</li> <li>▪ Pharmacy (including Part D)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Adaptive aids</li> <li>▪ Adult foster care</li> <li>▪ Assisted living/residential care</li> <li>▪ Personal emergency response system</li> <li>▪ Supplies and DME</li> <li>▪ Home modifications</li> <li>▪ Nursing services</li> <li>▪ Home therapy</li> <li>▪ Respite care</li> <li>▪ Personal assistance services</li> <li>▪ Day activity program</li> <li>▪ Long-term nursing facility</li> </ul>	<ul style="list-style-type: none"> <li>▪ Service coordination</li> <li>▪ Non-emergency transportation</li> <li>▪ Routine dental</li> <li>▪ Weight loss programs</li> <li>▪ Smoking cessation</li> <li>▪ Financial counseling</li> <li>▪ Home-delivered meals</li> <li>▪ In-home monitoring system</li> </ul>

## COORDINATION WITH MEDICARE

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

A full integration of Medicaid and Medicare services for those receiving both Medicare and Medicaid benefits within MLTSS creates a more streamlined system for care delivery and provider payments. Aligning Medicaid and Medicare funding helps ensure that the coordinated care model can deliver services across the full spectrum of needs most efficiently.

DHH's MLTSS program must cut across traditional Medicare and Medicaid service boundaries so that services across the two programs are delivered seamlessly. Such a blending will lead to positive health outcomes, high consumer satisfaction, overall cost-effectiveness, and savings. The greater flexibility made possible leads to broader innovation by plans and the state alike. Last but not least, providers are more likely to participate if reimbursement procedures are simplified through integration.

To simplify enrollment procedures and ensure that needs are efficiently addressed in a holistic and timely manner, DHH should work with CMS in establishing a no-wrong-door policy for dual-eligible individuals seeking to enroll in the MLTSS program. A single point of access means that members avoid bouncing between the Medicare and Medicaid programs to access services or get providers reimbursed, getting lost in the requirements of each program.

Similarly, DHH should mandate that the call centers of participating MCOs be staffed with member representatives knowledgeable about the benefit packages available through both programs and the importance of coordination of benefits. MCO member representatives can help members recognize gaps in care and schedule or reschedule appointments or, as appropriate, transfer the member to his or her care manager.

## Federal Assistance through My Place Louisiana

DHH's use of federal incentives enacted to encourage state compliance with the *Olmstead* mandate would also facilitate a rapid and cost-effective rebalancing of services. For instance, the Affordable Care Act included a five-year extension of the existing Money Follows the Person rebalancing demonstration through 2016. This demonstration, known in Louisiana as My Place Louisiana, provides the state with an enhanced federal matching rate for 12 months for each Medicaid beneficiary transitioned from an institution to the community.

## Provider Network Adequacy Standards

In designing its MLTSS program, Louisiana will want to consider approaches that tailor provider network access standards to the service needs and geographic locations of Louisiana beneficiaries. Medicaid MLTSS programs in other states have developed standards that can be modified to provide an appropriate fit for a Louisiana MLTSS program. The state can help to safeguard network adequacy, especially in remote rural areas, by requiring that providers contracting with any one MCO contract with all participating MCOs and, at least in the program's transition years, that all providers be reimbursed for MLTSS services at the Medicaid FFS rate. After that participation mandate has expired, network adequacy standards should allow the MCO to utilize nonparticipating providers who agree to accept the Medicaid FFS rate, particularly when lack of access to a member's existing provider will impact continuity of care. This would help to make it possible for all members to access an all-inclusive network of medical providers and minimize provider concerns about participation.

## FOCUS ON REBALANCING

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

DHH needs MCO partners who can successfully transition members into the community, support them effectively, and develop programs to increase the capacity of service providers. The goals of participating MCOs should be similar to the goals of DHH—rebalancing LTSS funds, promoting the use of home and community-based services and transitioning members from facility-based care, improving care coordination, establishing effective care planning, and promoting consumer direction.

An MCO participating in the MLTSS program should be able to deliver LTSS in a way that is meaningful for and respectful of members, their families, and caregivers. It should administer an integrated benefits package across the spectrum of care, including physical health, behavioral health, and LTSS, to meet the unique needs of Louisiana MLTSS members, with the understanding that members are at the helm of the program. Providing choices for members to enhance their quality of life should guide every participating MCO in everything it does.

Participating MCOs should be able, while maintaining costs, to promote and steadily increase the number of MLTSS members living in communities. At the same time, MCOs should be prepared to work with institutional providers to see that they are providing quality services and that institutional placement is reserved for those members who lack supports in the home and community.

### Care Coordination Approach

Care coordination should be at the heart of what every participating MCO does, and it should have a best-in-class team of care coordinators recruited and trained to provide members with quality services and supports. It should utilize robust care coordination tools and systems that support member engagement, facilitate coordination of care, and encourage active member participation in service delivery. A participating MCO's approach to service planning should emphasize member choice, self-determination, and community integration. Whether the member is in a nursing facility or home and community setting, the MCO should be focused on member engagement. Care coordinators should partner with members, their families, and caregivers to identify each member's unique needs, strengths, and preferences.

## Transitioning Institutionalized Members

Louisiana's MLTSS should require a comprehensive assessment of the physical, behavioral, social, and functional needs of members residing in nursing facilities on enrollment and periodically thereafter to determine the member's interest in and ability to transition to the community. Members residing in nursing facilities may also be identified for transition through other processes, including referral from nurse practitioners, nursing facility staff, providers, family members, or faith-based and community-based organizations. See *Serving the Community Choices Waiver Population*, pages 8-9 for more information.

## Plan Principles for Self-Directed Care

We encourage DHH to include services within the MLTSS program that allow and encourage self-direction to the fullest extent and with the broadest range of services possible. Transitional assistance should include the assessment and provision of community and in-home support services that help members self-manage their conditions or disabilities and maintain an optimal level of physical, cognitive, and behavioral functioning. Self-direction maximizes members' involvement in the development of their care and services plans and in selecting, hiring, and directing caregivers and services.

## Culture of Quality

Participating MCOs should have a culture of quality embedded in every aspect of their organization, encompassing clinical care and services, and including physical health care, behavioral health care, and MLTSS services. They should be able to monitor and measure member and provider satisfaction as part of their quality and continuous improvement efforts. They should seek continuous input on the planning and delivery of MLTSS through advisory groups comprised of members, providers, stakeholders, nursing facility representatives, and HCBS providers.

## Supporting Integrated Care through Technology

Through the use of technology, participating MCOs should have fully integrated administrative, financial, and clinical functions to support on-going management, monitoring, and continuous quality improvement. The MCO should be able to streamline member assessments and more directly engage members through the use of field-based screenings. The MCO's fully integrated system should provide all care team members access to the same documentation system, allowing information and data to be shared seamlessly.

## Fully integrating Disease Management

A participating MCO should have a disease management program fully integrated into the MLTSS care coordination program. Care coordinators serving as the primary point of contact for all members should promote disease management goals and activities. The member's wellness goals and disease-specific interventions should be addressed and integrated into a member-centric plan of care.

## Linkage with Local Agencies for Services and Supports

MCOs participating in the Louisiana MLTSS program should embrace engagement with local and faith-based service agencies, such as Area Agencies on Aging and Disability (AAAD), Louisiana AARP, Centers for Independent Living (CIL), and ID/DD Organizations such as the ARCs and Support Coordination Network that exist throughout the state and are trusted by members. These trusted stakeholders will facilitate smoother member and provider transitions into MLTSS during implementation and help to maintain solid, transparent relationships. In addition, they should be able to help utilize My Place Louisiana program funds to augment health plan medical services with local community nonmedical services.

## CONSUMER PROTECTIONS

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

Incorporating the insights of stakeholders, including members, providers, and advocacy groups representing all impacted MLTSS participants, will provide information instrumental for Louisiana's planning and implementation process, and subsequently for its ongoing oversight of the MLTSS program. Stakeholder engagement and collaboration are critical components for ensuring a smooth, efficient transition to MLTSS through transparency of program design.

Both national and local advocacy groups are often able to provide valuable input into MLTSS program operations through mechanisms that facilitate direct feedback, ensuring members can play a primary role in assessing the quality of their services and service providers and helping to build member satisfaction. The program should require MCOs to create effective feedback forums that enable members to fully participate in program development and operations. Finally, MCOs must have processes in place to recognize and fully and effectively resolve system issues, grievances, and complaints of abuse, neglect, and exploitation in an effective and timely manner.

### Choice and Consumer Supports for Self-Directed Care

The Louisiana MLTSS program should support a person-centered approach designed to meet its members' medical and nonmedical needs, and support them in achieving the quality of life and level of independence they seek. There must be active participation by the member and his or her designee/personal caregiver in the service planning and delivery processes. In addition, the individual should be able to self-direct his or her services in a way that fosters independence, hiring and firing caregivers, and directing the way services are provided.

MCOs should have experience providing education and materials for consumer direction. Care coordinators should have extensive hands-on experience to help members successfully direct their services and provide on-the-job training and shadowing for other plan employees.

In addition, to ensure that care and services always are designed to meet the member's immediate needs, service plans should be reviewed and updated on a regular basis, always with the participation of the member and, where appropriate, his or her family caregivers and designees.

## Corrective Action for Untimely Access

We also recommend that DHH require participating MCOs to monitor their network providers to confirm they are providing members with timely access to care and services. When a provider is found to not be complying with access requirements, the MCO should be expected to develop, implement, and monitor an appropriate corrective action plan for the provider.

## Call Centers Representatives and Member Advocates

Customer care representatives contacted through call centers are often a member's first exposure to the MCO. Call center representatives should serve as program ambassadors and help lay a foundation of friendly, knowledgeable assistance in helping members with enrollment/disenrollment decisions and procedures, as well as provider selection and requests for member information. Call centers should be staffed with member representatives knowledgeable about the membership, the benefit packages available through both programs, and the importance of coordination of benefits. MCO member representatives can help members recognize gaps in care, scheduling appropriate appointments, rescheduling missed appointments, or transferring the member to his or her care manager.

MCO member advocates should be accessible to members by telephone to assist members with any issues they may have—from the time of enrollment through care management and the delivery of services, to transportation and caregiver supports, to provider reimbursement for their episode(s) of care and service. Member advocates should be culturally competent and may be behavioral health peer specialists, people with disabilities, or aging adults who have experience with person-centered care, self-direction, and other relevant issues. MCOs should be required to monitor member calls at all times to see that members receive the best service.

## Cultural Competency

The state of Louisiana is home to a range of diverse cultures and languages. A culturally competent approach to providing MLTSS in the state must embrace the cultural beliefs, preferences, expectations, and norms that influence how and where members access healthcare services and engage with their service and care providers so that care and services can be designed and delivered in accordance with those beliefs. Interpretation services and translated materials must be offered and provided when requested. Plans should develop multi-cultural call center systems for assisting non-English-speaking members in scheduling appointments, obtaining medical advice, and navigating the health care system.

## Continuity of Care

Every participating MCO should provide a transition period for moving between FFS LTSS and MLTSS under an aggressive timeline that facilitates continuity of care by accommodating participation by a beneficiary's existing provider—for a period of no more than 90 days—until the provider is able to contract with the participating plan's network, the beneficiary is able to find a network provider with which he or she is comfortable, or the beneficiary's health care assessment and personal care plan suggest the need for another provider. Out-of-network providers accommodated through this process should be reimbursed at Medicaid FFS reimbursement rates. In at least the initial years of the MLTSS program, providers who contract with any MCO should be mandated to contract with all participating MCOs to help maintain continuity of care through participation by all available providers.

## Protection from Abuse, Neglect, and Exploitation

Various studies have demonstrated that older adults who are victims of violence have more health care problems than other older adults, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems. This underscores the importance of each participating MCO monitoring, detecting, and remediating in a timely and effective manner reports and evidence of abuse, neglect, and exploitation. DHH should also establish a statewide MLTSS ombudsperson specifically designated to provide support and remediation for issues not addressed through MCO appeals and grievance processes or the state fair hearing process. In addition, MCO representatives should work with the existing statewide ombudspersons on a regular basis to ensure internal practices are up-to-date and meeting state law standards.

## Appeals and Grievances

Participating MCOs should respond to member complaints and grievances in a courteous and professional manner and work to resolve any issues that may arise. MCO quality management departments should research all member service complaints, and track and trend complaints to identify systemic or provider issues in need of improvement. The information collected should be shared with staff at all levels within the organization. MCOs should also take proactive steps to address identified issues before a complaint is received, developing employee educational materials and targeted training to address common issues.

Appeals should be similarly viewed as indicators of potential process improvement opportunities. MCO hearings should be fair and scheduled in a timely manner, with an opportunity to exhaust all internal procedures before seeking redress externally.

## PROVIDERS

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

### Enhancing Existing Provider Networks to Ensure MLTSS Network Adequacy

Any MCO network operating within the Louisiana MLTSS program should include providers who traditionally serve the covered population, including Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), home- and community-based providers, nursing homes, assisted/residential living, FQHCs, rural health clinics (RHCs) and other safety net providers. The goal of any network adequacy standards should be to support members' health and independence, and a robust network of providers across the state will be required to meet member's needs in their homes and communities. Plans must be able to demonstrate an adequate network as measured at a minimum against the existing program's service area.

DHH should require that MCOs have at least two network attendant care providers per parish, as well as a specified reasonable number of HCBS providers to provide such services as meal delivery and home modifications. In addition, participating MCOs should be able to demonstrate expertise in developing and/or expanding new offerings of services, including working with providers to expand service areas and offerings and to attract new entrants to the program.

As noted previously, DHH can help to maintain network adequacy by requiring that a provider contracting with any MCO contract with all MCOs, at least in the initial years of the MLTSS program. DHH can incent HCBS provider participation by requiring payment to non-network providers at Medicaid FFS provider reimbursement levels, at least in the initial years.

### Reimbursement and Claims Practices

DHH should require that MCOs put in place sound reimbursement practices and ensure prompt and accurate claims payment. At a minimum, there should be a prompt pay standard that is reasonable to administer but also demonstrates to the state and MLTSS providers that they will not face cash flow issues from MCO claim processing issues. An example might be to require that 90 percent of clean claims be processed and paid within 20 business days of receipt and 100 percent within 30 business days of receipt for all claims.

DHH and participating MCOs will need to also develop specific reimbursement policies for HCBS providers that recognize the fragile financial status of those providers. Setting a separate and distinct prompt payment policy for those providers—perhaps within 15 days of receipt—will help keep those providers afloat. DHH and the participating MCOs may even want to consider paying those providers as frequently as twice weekly.

In any event, participating MCOs must understand the differences between LTSS providers and other providers and be prepared to develop strategies to support their transition to a MLTSS payment structure. MCOs should also be able to demonstrate that they have the technologies, telephonic support capabilities, and face-to-face support resources to assist MLTSS providers.

## Continuity of Care

The state of Louisiana should institute a continuity of care period requiring all services be provided to a member as authorized prior to implementation of the MLTSS program, for a period of up to 90 days or until such time as the MCO can perform a complete care assessment and facilitate an orderly transition of any care needed.

It is also critical that the state establish a process to seamlessly transfer existing care plans to the new MLTSS providers. MCOs should be required to complete initial assessments on all MLTSS members within reasonable time frames. It is our experience that these initial contacts with the MCO care manager are invaluable for evaluating current member needs, updating care plans, and addressing gaps in care that place the ability to live independently at risk.

## Specialized Provider Relations Support

Provider relations representatives should be able to answer questions from providers and offer provider education specifically centered on care coordination, claims submission in billing, prior authorization, and transitions. In addition, to maintain a high level of provider satisfaction, provider relations representatives should be prepared to conduct frequent site visits and develop specialized provider programs designed to facilitate integration.

Education and communication will be particularly critical as implementation gets under way, as many LTSS providers may be new to the Medicaid program broadly and MLTSS specifically. Immediately before, and for the first year following implementation, MCOs should have provider training materials that address provider questions, as well as scheduling face-to-face webinar and telephone training geared to providers' needs.

## Educating Providers in Transitioning from FFS to MLTSS

MCOs should be able to demonstrate experience in transitioning from FFS to MLTSS. MCOs should be prepared to offer robust provider training throughout the state. Plans should be required to have programs that offer ongoing and frequent educational sessions so that new workers can become familiar with the Medicaid program broadly and the MLTSS program specifically. Education programs should be especially focused on reaching direct care workers, given the high state turnover rate for those workers.

## Billing Assistance for Transitioning Providers

Smaller nursing facilities and home- and community-based service providers may need additional support on claims submission as they transition from a FFS model to managed care. MCOs should expect to work closely, well after implementation, with long-term care (LTC) providers on billing, with targeted training on claims submission and payment. In addition, a LTC provider hotline should be staffed with representatives who understand provider needs.

## Prior Authorizations

DHH may want to consider an approach under which MCOs proactively issue authorizations for members that continue to be operative as long as there has been no change in the patient's condition. This approach reduces the administrative burden on the LTSS provider; the provider only has to make a follow-up request for authorization when the member's condition changes.

## CHOOSING YOUR MCO PARTNERS

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

To best serve Louisiana's adults who are aging and persons with disabilities, DHH should seek MCOs that understand the diverse needs of adults who are aging and persons with disabilities and utilize tried and tested solutions in coordinating and accessing the appropriate services. Based on the MLTSS experience of our affiliates in other states, Amerigroup suggests MCOs be selected for participation based on the following considerations.

### 1. Demonstrated Experience in Coordinating Services within LTSS

Participating MCOs should have previous organizational MLTSS experience and demonstrated best practices that can be applied and enhanced to accommodate the unique needs of Louisiana's aging adults and persons with disabilities. DHH can measure degree of experience based on the number of members served, the number of LTSS contracts, the range of services managed in any given contract, and the demonstration of innovation in managing LTSS.

### 2. Experience Coordinating Services for Dual Eligibles

DHH should select MCO partners with broad organizational experience coordinating services for Medicare and Medicaid in the most seamless and integrated manner. MCO care managers should be experienced in authorizing services across a range of acuities and care settings, matching the member's needs and preferences and meeting authorization criteria.

### 3. Experience Assembling an LTSS Provider Network

As with traditional managed care, MLTSS plans must have an adequate network of qualified providers to meet the needs of their enrolled beneficiaries. While current credentialing and network adequacy systems have been developed based on an acute and primary care service delivery model, CMS expects states to ensure that managed care networks also meet the needs of MLTSS participants, including adequate capacity and expertise to provide access to coordinated, person-centered care and services in home- and community-based settings, employment supports and the provision of training and technical assistance to providers. A qualified MLTSS network is one not only comprised of a broad range of services, but also one that responds to the needs of members using a diverse set of providers who understand the needs of a culturally, linguistically, physically, and developmentally diverse membership.

The network adequacy standards the state puts in place should be clearly defined and appropriate to the specific geographic areas and populations covered by the program. This is important because often contract requirements for subpopulations may need to be outside the "norm" of traditional provider and community standards. Plans should have some degree of flexibility in designing networks that recognize challenges in rural and remote regions. Amerigroup supports the use of telemedicine as a means to bolster networks in distant areas, particularly for behavioral health services.

## 4. Cultural Competency

Understanding members through a commitment to cultural competency creates an inclusive, accepting environment in which members can receive information and education in their language if other than English. Interacting effectively with members requires an understanding and appreciation of their cultural beliefs so that care and services can be designed and delivered in accordance with those beliefs. See *Cultural Competency*, pages 31-32.

## 5. Integrated Behavioral Health Capabilities

Nearly one-half of all people in the United States will meet the clinical criteria for having a mental health diagnosis over the course of their lives.<sup>3</sup> Despite the prevalence of behavioral health needs and the impact mental health and substance use can have on a person's physical health, these two areas of health care traditionally have been compartmentalized. Behavioral health services have often been carved out from Medicaid managed care plans and delegated to entities focusing exclusively on mental health and substance use services. Only in recent years have efforts taken hold to integrate behavioral health services with primary care.<sup>4</sup>

Participating MCOs should be prepared to fully integrate behavioral health and substance abuse services with acute care to maximize service coordination and effective service delivery. MCOs should be able to demonstrate proper member screening and assessments that include screening for substance abuse, community living support planning, and service coordination techniques, including medication management and provider communication and training. MCOs should require PCPs to complete behavioral health screenings during the member's initial assessment and whenever there is a suspicion a member may have a behavioral health condition, including those conditions that may be affecting physical health care and vice versa.

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<sup>3</sup> American Public Health Services Association and National Association of State Medicaid Directors, "Serving the Needs of Medicaid Enrollees with Integrated Behavioral Health Services in Safety Net Primary Care Settings", Issue Brief (April 2008).

<sup>4</sup> Ibid.

## 6. Stakeholder Engagement

Based on our affiliates' experience in implementing new programs in other states, we recommend a planning process that engages all stakeholders, including consumers, families, MCOs, providers, local and national advocacy groups, legislators and other parties. All stakeholders should be kept well informed of program decisions and be encouraged to contribute to program development. Stakeholder empowerment, ownership and investment will result in a more effective program. See *Louisiana's LTSS Program Should Serve All Waiver Populations: Early and Effective Stakeholder Engagement*, page 5. Also see, *Consumer/Stakeholder Engagement*, page 14.

## 7. Efficiencies in Administration

Participating MCOs should demonstrate administrative efficiencies in coordinating efforts between providers, members, and the health plan. The experience of Amerigroup's affiliates in other states has demonstrated that these investments save time and yield better results for our members.

## 8. Quality Management

Amerigroup recommends that participating MCOs have mechanisms for reporting performance on quality measures, utilization management, disease management, caregiver support and transitional care that seek to continually improve member health outcomes and deliver efficient and effective care. See *Measuring Quality and Outcomes*, pages 42-43.

In addition, MCOs should be expected to recognize that employees who directly interact with members and providers are critical to adopting quality-driven culture and to effecting the change desired in performance improvement projects. Employees in these roles should be educated in the organization's quality management structure, as well as the measures and metrics being used to monitor quality of care. Making the goals of an MCO quality management program known to employees will motivate and incent them to be more active in meeting quality standards.

## 9. Accountability

DHH should ensure it partners with MCOs in the new LTSS program that take fraud, waste and abuse seriously. With their closer proximity to the members and providers themselves, MCOs are naturally effective partners in detecting and preventing fraud, waste and abuse. Participating MCOs should:

- Have a robust fraud, waste and abuse plan or policy in place that includes an education initiative for employees, contracted providers and the program beneficiaries they serve;

- Have successful track records in detecting and preventing fraud, working with external resources such as state regulatory agencies and law enforcement and prosecutorial entities; and
- Utilize technology, including data mining and anti-fraud tools, to enhance their efforts.

DHH can make MCOs active partners in this effort by setting specific contract goals relating to fraud, waste and abuse. DHH should consider contract requirements that:

- Hold participating MCOs provider network recruiting and credentialing processes to a standard that deters unscrupulous providers from joining the MCO's network;
- Require that participating MCOs be financially sound, with adequate reserves, and able to provide the services contracted;
- Expose MCOs to a potential financial liability for fraud, waste and abuse committed by the plan, members or providers; and
- Require participating MCOs to utilize front-end predictive modeling methodologies in claims processing, rather than a post-payment pay-and-chase approach.

In addition, DHH should permit participating MCOs to utilize extrapolation in their audits of providers. The use of a valid, statistically sound extrapolation audit, conducted in accordance with CMS guidelines, may be the single most efficient and effective method to seek redress from providers engaging in fraudulent or abusive billing.

## SERVICE COORDINATION

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

Any MCO selected to provide MLTSS must understand the complex medical, functional and behavioral health needs of members. Participating plans should be accustomed to addressing the social and economic challenges that exacerbate the health, behavioral and social conditions of individuals needing LTSS, compromising their abilities to optimize their health and functional status. Any service coordination/conflict-free case management model offered must recognize the balancing required to holistically address the myriad needs of these populations, as well as the interests of their families and caregivers, providers and community supports.

### Designing Optimal Service Coordination

MCOs participating in the LTSS program should be prepared to make available all covered and appropriate physical health, behavioral health and community-based and institutional LTSS delivery options. Furthermore, MCOs should work with DHH to see that the managed care contract incorporates best and promising practices, with input from stakeholders.

At the same time, decisions regarding which services should be provided to individual members should be made individually, based on need, in concert with the individual and their support teams and personal caregivers, so that individuals are receiving the most appropriate care and services for their healthcare, functional and social support needs.

Given the involvement of multiple types of providers and the high levels of co-morbidity among aging adults and persons with disabilities, there must be a focus on coordination with providers across the continuum of care. MCOs that coordinate comprehensive and integrated service packages are better able to provide quality delivery of the covered services. Benefit carve-outs impede a health plan's ability to coordinate and manage care and effectively review and thus improve health outcomes. When all covered services—including integrated physical health, behavioral health and LTSS—are provided through the MCO, the MCO staff and/or providers developing and monitoring care plans can provide comprehensive person-centered service planning and oversight of care across all available settings.

Ensuring members' medical and non-medical needs are met and that they have the quality of life and level of independence they desire within the MLTSS program starts with person-centered processes. The critical components of person-centered service coordination are listed at *Consumer Independence*, page 15.

To ensure these critical components are present, DHH should seek MCOs like Amerigroup that have the depth and breadth of experience delivering the full range of services and service coordination required by members with disabilities and adults who are aging, including those individuals needing a nursing home level of care, LTSS services through home and community-based waivers and Medicaid-Medicare dual eligible program services. MCOs should be skilled at building and coordinating an extensive services network that enables members to achieve their highest potentials for their health and live in the community.

## Important Design Elements

To fulfill DHH's goal of offering its MLTSS program participants an optimal level of service coordination, we recommend that DHH mandate the following elements for inclusion in service coordination:

- Require that MCOs develop provider networks that are specifically attuned to the medical, behavioral and social and support needs of aging adults and persons with disabilities participating in the MLTSS program and their families;
- Require MCOs to provide aging adults and persons with disabilities needing LTSS with a single-door, culturally sensitive contact for help in navigating the complex system;
- Incorporate, into the capitation rate calculated for MCOs, the costs of the service coordination function;
- Require that each member undergo a health assessment within the first 90 days of the program, the results being used in developing the member's care plan;
- Require members who appear to be at higher risk to be assessed within 60 days;
- Mandate that MCOs engage members and their families or caregivers in the process of developing the care plan and encourage members to self-direct their own care and services;
- Address the member's social and environmental barriers to success as they arise;
- Require each MCO to maintain active linkages to, and contract with, existing community medical, behavioral and social service providers within the Louisiana community;
- Mandate that MCOs conduct clinical analyses of member data to identify gaps in service coordination across the various member settings;
- Focus care planning for nursing facility residents on reintegration into the community; and
- Focus care in community settings on diversion from care in an institutional setting.

## MEASURING QUALITY AND OUTCOMES

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

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

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

Amerigroup has found that there is no uniform system of metrics for measuring the quality of care received by adults who are aging and persons with disabilities in each of the various care settings, including their own homes. Where some quality measures do exist, they are often inappropriate to the care that adults who are aging and persons with disabilities receive or to the settings in which—or the providers from whom—they receive care.

Where possible, the state of Louisiana should be prepared to implement MLTSS quality measures that build on existing widely accepted, evidence-based and peer-reviewed measures of quality. However, DHH will need to implement quality measures that are specifically tailored to the populations enrolled in the MLTSS program. Measures should reflect and address the LTSS user's home environment, care setting, quality of life, the participation of caregivers, use of self-direction, social interactions, and the abilities and level of independence of the individual. They should include quality of life measures designed to promote enhanced self-care, personal preferences, and independence through improved service coordination, community integration and involvement, expanded accessibility to assistive technology and enhanced participation in the economic mainstream. Process measures should be used only where the process demonstrably leads to improved health outcomes (where potentially possible or maintained health outcomes where not) and an improved quality of life.

MLTSS measures should include HEDIS measures of access to care and care plan evaluation and management, as well as appropriate medical outcomes measures. HEDIS measures should focus on members with chronic condition measures and on behavioral health measures, and include such measures as controlling blood pressure, diabetes, asthma, and COPD, use of antidepressants and follow-up after mental health discharge.

CAHPS measures of member and caregiver satisfaction should also be utilized.

MLTSS-specific measures should also include rate of deinstitutionalization, avoidance of placement in an institutional setting, ratio of placement in an institutional setting to HCBS placement, readmission to a nursing facility within 60 days of discharge, mortality, emergency

room use, community inclusion and meaningful employment, timely resolution of allegations of abuse or neglect and falls leading to injury.

Finally, measures of performance should align with value-based purchasing approaches and goals. Service coordination, the efficient utilization of services, financial viability, joint accountability, beneficiary access, smooth care transitions, beneficiary safety and transparency should all be goals of any quality measures system.

Whatever measures are used, it is important that the process to develop these metrics be collaborative between the MCOs and DHH. Final technical specifications for the measures must be clearly communicated to MCOs, providers and relevant stakeholders.

## Ongoing Stakeholder Involvement

To achieve long-term success, participating MCOs must foster discussions among all relevant stakeholders to recognize achievements in care and identify areas for improvement.

Amerigroup and its affiliates have experienced the value that stakeholders bring to program design, implementation and quality enhancement. Across all contracted states, our affiliated health plans have greatly benefited from input and feedback from local member advisory groups, who:

- Identify and help to leverage community resources;
- Assist in program design in areas of member rights, complaints and grievances, marketing, member services, outreach, health needs, accessibility, and cultural competency;
- Provide feedback and make recommendations on how to integrate physical, mental health and substance abuse services;
- Make recommendations on collaborating with community organizations and communication with constituents regarding implementation of Medicaid programs, Benefits, and services; and
- See that materials and programs meet cultural competency requirements, are fully accessible, are understandable and address their health education needs.

The quality improvements precipitated by feedback from our Member Advisory Board (MAB) in New Mexico demonstrate how Amerigroup uses member advisory group feedback to improve quality and services. The New Mexico MAB was instrumental in developing two gender-specific wellness guides that are incorporated into every mailed welcome packet. They contain removable charts that can be carried to PCP appointments.

## ACCOUNTABILITY

*In conjunction with the quality and reporting requirements, DHH seeks feedback on effective contractual and rate methodology strategies that promote high performance from our partners. This could include financial penalties and awards for performance, how to tie these to outcomes in a way that promotes the program's goals and mission, and other tools that ensure adequate accountability from the MCO.*

### Accountability through a Capitated Rate and Incentives Payment Structure

In the process of constructing an MLTSS program, all participating MCOs and DHH should discuss assumptions, population trends, and calculations for risk and contingency. MCOs such as Amerigroup, with broad experience in many states with similar programs, can assist DHH in developing best practices. The rate structure should be developed through a process that is transparent and collaborative between the contracted parties (e.g., the plan and the state), to establish a relationship based on trust with participating MCOs. If the participating MCO is a full partner with the state, it will be incented to actively search out and recommend program upgrades to further strengthen the MLTSS program.

DHH should seriously consider a blended payment rate for all members; the rating structure should reflect both the diversity of the population as well as the challenges of moving from institutional care to community-based care. MCOs should be held accountable through capitated rates that require them to bear the risk for keeping members in the community and out of institutions. Those capitated rates should be certified to show actuarial soundness and be risk-adjusted in alignment with expected resource usage for each eligibility group. The risk adjustment approach for the TANF/CHIP populations may not be appropriate for the LTSS population; a regression model based on ADLs may be more appropriate if a strong enough correlation can be maintained. Rates need to be blended based on the anticipated mix of clients living in facilities and in the community.

The rate structure should recognize the current imbalance between nursing facility and home- and community-based services, encouraging the delivery of high-quality services in home- and community-based settings and supporting the goal of community integration. In addition, rates should reflect the unique opportunities presented by MLTSS that are not available through traditional Medicaid.

## Embedding LTSS Quality Measures

Creating a pay-for-performance program that extends to the LTSS provider network achieves both quality and accountability for participating MCOs and the state by aligning provider incentives with member outcomes. Designing and implementing an MLTSS pay-for-performance program begins with defining relevant quality measures. We have laid out our primary recommendations regarding applicable plan quality measures previously in this response, at *Measuring Quality and Outcomes*, on pages 42-43.

Additional care quality measures could assess the level of integration of Medicaid and Medicare services, with MCOs being evaluated on how well they have integrated their internal systems and processes to ensure seamless health care delivery systems for Medicare and Medicaid services. Operational integration could be measured by such criteria as a single call center, a single complaint system, or a single member handbook.

## IMPLEMENTATION

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

In Amerigroup's experience, one of the most important elements in successful implementation of a new LTSS programs is establishing a deliberate planning process which involves all stakeholders in open and frequent dialogue about the program design and policy decisions at early stages of the process. A strong partnership from the program's outset between the state and participating MCOs fosters greater collaboration and problem-solving toward mutual goals. Such an approach promotes transparency in program policy development and a mutual understanding of the costs and resources necessary to ensure the long-term viability of an MLTSS program.

We believe that implementation can be completed in 6-12 months if there is adequate time afforded to allow all interested stakeholders the opportunity to engage in the process of program development. A DHH partnership with an MCO like Amerigroup—already on the ground and effectively serving the Bayou State Medicaid population, with strong existing partnerships with local providers and established member satisfaction—should facilitate a more rapid, if still deliberate, expansion of LTSS services.

### Recommended Implementation Rollout

Amerigroup recommends a track for implementation parallel to that taken to implement the Bayou Health three-part geographic rollout in 2012. Following this formula, the three-part rollout would begin with General Service Area (GSA) A Regions 9 and 1, followed by GSA B regions 2, 3, and 4, and concluding with GSA C Regions 5 through 8. We also recommend that DHH avoid any disconnect in enrollee services and a fragmented approach by creating a holistic rollout of services in each region. Any attempt to stagger enrollment by either service needs or populations would only create confusion.

An Implementation Project Management (IPM) Team should be responsible for activities in all three GSAs, creating the most synergistic approach across the state for all enrollees. The IPM Team should be comprised of MCO staffers and DHH staff. As Amerigroup has been live in the state since early in 2012, is well versed on how to serve the specific needs of members receiving LTSS, and has experience with this specific type of implementation, we would be pleased to serve on any IPM created, pulling from the best practices of our affiliates in other states over the decades to ensure that the transition from the implementation phase to operations is smooth and seamless.

## Partnering with Stakeholders

All stakeholders must be engaged as early as possible and at every stage of the planning and implementation process to help identify key issues and needs and develop actionable solutions. As noted previously, it is essential to recruit and contract with providers and advocates who traditionally serve aging adults and persons with disabilities, and as well as provider advisory groups, member advocacy groups and others who offer specialized services and supports. These organizations are valuable assets for supporting a holistic approach to healthcare, including necessary non-medical services and supports, as their services promote independence and offer real choices.

Provider and beneficiary educational tours, multiple educational mailings, transparency in design and oversight of the program by posting materials on an MLTSS website and state and managed care plan advisory groups are all good examples of ways the state can meaningfully engage stakeholders. Ongoing stakeholder involvement after implementation provides critical feedback for program improvements.

## Building a Sufficient Provider Network

Before the program goes live, DHH must ensure that participating MCOs have built and are able to maintain successful provider networks to support enrollees' care and services needs throughout the continuum of care. The state should develop and have in place clearly defined policies to ensure adequate network capacity that is appropriate to the specific geographic areas and populations covered by the program. These policies should help to ensure access to (1) community-based providers that offer essential local services; (2) ancillary providers that extend services, service locations and enrollee preferences; and (3) non-traditional providers to accommodate cultural needs and accessibility. In addition to geographically-appropriate standards for access to services, network adequacy standards should address provider certification requirements and training and technical assistance for providers.

Network adequacy also can be facilitated by DHH standards that encourage MCO to have sound provider reimbursement practices, with prompt and accurate claims payment, and practices to simplify and minimize administrative burdens such as on-line claims submissions.

## Closing Network Gaps

In setting standards for network adequacy, current acute care provider requirements should prove adequate for the MLTSS program, but DHH will need to clearly define access requirements for home- and community-based LTSS providers. DHH should mandate that MCO networks include at least two attendant care providers per parish.

DHH may also want to consider requiring MCO provider service departments to monitor their networks through mapping software and regular provider and member communications to ensure uninterrupted service delivery to MLTSS populations. Plans should at least be required to quickly rectify access issues identified by members through the member complaint process.

If participating MCOs encounter barriers to assembling adequate provider networks, DHH may want to consider authorizing additional interventions to ensure no potential member is without adequate access. Such options can include transportation to a nearby parish for care or use of mobile services, as well as single case agreements providing for payment to out-of-network providers at Medicaid FFS reimbursement rates. The state can help to safeguard network adequacy, especially in remote rural areas, by requiring that providers contracting with any one MCO contract with all MCOs and—at least in the program’s transition years—at the Medicaid FFS reimbursement rate. Amerigroup also recommends use of telehealth in rural areas where provider access is limited, particularly for behavioral health.

## Rate Structure

Aligning payment structures with MLTSS program goals supports a diverse, quality provider network, improves the health of populations and the beneficiary experience of care and reduces state costs. Capitation rates that encourage the delivery of high-quality services in home- and community-based settings and support the goal of community integration are effective tools in achieving those goals. Rate-setting should be open and transparent among contracted parties (e.g., the plan and the state), achieved with cooperation with participating MCOs. An MCO that is a full partner with the state will be incented to actively search out and recommend program upgrades to further strengthen the MLTSS program in an ongoing manner.

Capitated rates for each of the eligibility groups need to be certified actuarially sound based on a blend of the anticipated mix of clients living in nursing facilities and in the community. Rate structure should address any existing imbalance between nursing facilities and home- and community-based services. Rate cells for duplicative or unnecessary services should be eliminated. Rates should be structured to cover projected service costs plus administrative cost and margin and properly incentivize health plans to reduce the rate of institutionalization over the long-term. Rates should specifically reward effective care coordination.

Additionally, during the initial years of the shift to LTSS services, rates should be subject to meaningful risk corridors to protect participating MCOs from extraordinary and unexpected costs and to protect the state from unexpected losses. Rates also need to include the costs of the federal health insurance tax on Medicaid MCOs, including the non-deductibility of that tax.

## Providing Recipient Information to Participating MCOs

Finally, prior to implementation, participating MCO(s) will need membership information to enhance the potential transition members from institutional settings to community-based settings. The member data provided should include a listing of current members, their assigned primary care providers, and their claims histories for the previous 6 to 12 months, as well as identification of those currently in case management or having a potential for case management services. Data should also include a listing of recipients who have special health care needs or who have been diagnosed with specific combinations of illnesses and conditions, including mental illness/substance abuse or mental illness/chronic physical illness, and an indication of who is in disease management. DHH should also provide summary-level statistics for facility admissions as well as detailed listings of inpatient admissions and admissions to a psychiatric hospital or residential treatment center in the past 12 months.

## CONCLUSION

Amerigroup applauds DHH's continued commitment to a more integrated, robust and comprehensive MLTSS program that rebalances services between institutional and community settings through effective care coordination and self-direction. We enthusiastically look forward to working collaboratively with DHH—as well as OCDD, OAAS, and LaDDC—in helping the state continue its efforts to improve health care quality and outcomes by reducing care fragmentation while providing greater independence for members and their families through a wider selection of home- and community-based living and service options. An effective MLTSS program will help conserve state funds and support members in achieving healthy outcomes and independence.