A Response to the Louisiana Department of Health and Hospitals for the Request for Information for Medicaid Long Term Services and Supports

Submitted by Amerigroup Louisiana, Inc.

January 28, 2013
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Louisiana Department of Health and Hospitals
Lou Ann Owen, Medicaid Deputy Director
P.O. Box 90130
628 N. 4th St., Bienville Bldg., 7th Floor (70802)
Baton Rouge, Louisiana 70821-9030

RE: Amerigroup Louisiana’s Response to DHH’s Request for Information for Long-Term Services and Supports for Persons Enrolled in Louisiana Medicaid

Dear Ms. Owen:

Amerigroup Louisiana, Inc. (Amerigroup Louisiana), is pleased to submit a response to the Request for Information (RFI) for Louisiana’s Request for Information for Long-Term Services and Supports for Persons Enrolled in Louisiana Medicaid issued by the Department of Health and Hospitals (DHH) on November 29, 2012.

Contact Information

As the chief executive officer for Amerigroup Louisiana, I will serve as the plan’s primary contact for this RFI and am available by phone or email.

<table>
<thead>
<tr>
<th>Name</th>
<th>George Bucher</th>
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<tr>
<td>Title</td>
<td>Chief Executive Officer</td>
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<tr>
<td>Address</td>
<td>Amerigroup Louisiana, Inc. 3850 North Causeway Blvd., Suite 600 Metairie, LA 70002</td>
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<td>Telephone Number</td>
<td>(504) 836-8851</td>
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We greatly appreciate the opportunity to participate in this information-gathering process and look forward to speaking with you soon.

Sincerely,

George Bucher
Chief Executive Officer
Amerigroup Louisiana, Inc.

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(504) 834-1271

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Louisiana Medicaid Long Term Services and Supports RFI Response

Introduction

Amerigroup Louisiana is enthusiastic and supportive of DHH’s request to seek information and recommendations toward building a Managed Medicaid Long-Term Services and Supports (LTSS) program. We, along with Amerigroup Corporation and our parent company, WellPoint, are a leader in Medicaid program management. We’re also a leader in providing LTSS to member populations, with more than 15,000 members who currently receive LTSS services. We establish and maintain a disciplined approach to caring for those most in need of care and services.

With this RFI, we will show that we have the experience and knowledge to make recommendations and partner with DHH to help redesign the current Medicaid program. We will address DHH’s unique needs while presenting Louisianans with quality healthcare options.

Experience in Medicaid

Amerigroup Louisiana currently serves 144,000 members through Medicaid, Louisiana Children’s Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), and the Supplemental Security Income/Aged, Blind and Disabled (SSI/ABD) programs. Therefore, we have the established relationships and local knowledge to quickly and efficiently expand our programs while drawing on best practices from affiliate experience with LTSS program design. Also, we are a leader in Medicaid and long-term care program management. With approximately 4.6 million TANF, CHIP, SSI, and LTSS members nationally that represent low-income families, children, pregnant women, seniors and people with disabilities, our programs reflect our knowledge of what works, what matters, and what best serves members and the goals of the states we assist. A breakdown of the populations we serve by state is illustrated in Figure 1.
Our members are empowered by our programs because we design the programs to help maintain and improve our members’ health and address and step beyond barriers surrounding poverty.

Since more than 15,000 of our members qualify for both Medicaid and Medicare and/or require LTSS, we see this as an area of great opportunity for coordination of care and cost efficiencies. These members are a unique population and have a distinguishing set of characteristics. They can have high rates of chronic illness or can suffer multiple chronic illnesses that make treatment and services much more complicated — meaning they can sometimes need specialized health care services, which generally represents the highest costs for state programs. Consequently, this population represents an area of great opportunity — to streamline programs and reduce duplication via service coordination.

No matter the barriers or challenges, we design programs that surround each member with holistic care, embedding compassion, dignity, and empathy into our member-provider relationships that nurture and help create more positive outcomes for all. Our programs also emphasize the opportunity for our members to live independently whenever possible either in their own home or within the community.

For example, through working with our New Mexico (NM) health plan and their state partner, our NM plan aided 2,345 healthy dual-eligible members at imminent risk of nursing facility placement to remain in their homes. In Florida, we were able to help 379 members transition from nursing homes back into the community and helped 455 members previously in nursing homes for rehabilitation avoid long-term nursing home placement and transition back to the community in the last 18 months.
Populations and Program Design

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 and dual-eligible (Medicare and Medicaid) populations be served under a full-risk, mandatory enrollment, which would transfer all of the health care delivery risk to the contracted MCOs. We also recommend selecting the most qualified MCOs through a competitive request for proposal (RFP process). This is the approach that will result in a plan’s ability to manage across the full spectrum of benefits and services and will reduce the unnecessary segmentation of health care services; a better, more holistic approach for the member. In turn, this approach also allows for the highest quality, most sustainable design. Benefits and services should include acute, long-term services and supports, and nursing facility services. And, while all services must be supported by the premium, below are suggested services for this population:

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

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<tr>
<th>Acute Health Services</th>
<th>Long-Term Services and Supports</th>
<th>Other</th>
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<td>▪ Hospital inpatient/outpatient</td>
<td>▪ Adaptive aids</td>
<td>▪ Service coordination</td>
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<td>▪ Behavioral health inpatient/outpatient</td>
<td>▪ Adult foster care</td>
<td>▪ Non-emergency transportation</td>
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<td>▪ Skilled nursing</td>
<td>▪ Assisted living/residential care</td>
<td>▪ Routine dental</td>
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<td>▪ Rehab therapies (including physical, occupational, speech/language)</td>
<td>▪ Personal emergency response</td>
<td>▪ Weight loss programs</td>
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<td>▪ Outpatient diagnostic</td>
<td>▪ System</td>
<td>▪ Smoking cessation</td>
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<td>▪ Laboratory</td>
<td>▪ Supplies and DME</td>
<td>▪ Financial counseling</td>
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<td>▪ Professional services</td>
<td>▪ Home modifications</td>
<td>▪ Home-delivered meals</td>
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<td>▪ Ambulance</td>
<td>▪ Nursing services</td>
<td>▪ In-home monitoring system</td>
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<td>▪ Emergency room</td>
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<td>▪ Home health</td>
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<td>▪ Hospice (through FFS)</td>
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<td>▪ Transplant services</td>
<td>▪ Day activity program</td>
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<td>▪ Pharmacy (including Part D)</td>
<td>▪ Long-term nursing facility</td>
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The most effective, efficient approach is one rooted in comprehensive, consistent care, maximizing members’ independence, and valuing individuals’ preferences and personal choice. Whether the member needs acute care and help coordinating benefits and services or whether he or she needs a full range of both acute and community-based services and aid for caregivers, one plan can coordinate the experience required and the support needed.

It also drives significant cost savings for DHH while creating more satisfied consumers and improved health outcomes. Generally for those who meet the requirements for nursing facility level of care, this type of individualized managed care costs approximately one-third that of nursing facility care.
Components of a Results-oriented Approach

Creating a synergistic, cost-effective healthcare model for members receiving LTSS services requires programs that smoothly dovetail with one another. Providers and service coordinators must be able to receive and communicate current, accurate information, and the information from assessments must be able to support both positive health outcomes and the members’ health and DHH’s goals. In order to build an approach that serves these needs, we recommend that DHH seek out partners who have experience in the following:

- **Engaging Providers** — To help ensure measureable improvement in the health care status of members, MCOs should develop a plan to deliver results. Provider engagement strategies that include incentive for delivery of care and related services, collaboration of community- and faith-based providers, and ongoing education and materials equip providers with the necessary tools to affect health outcomes.

- **Conducting Assessments** — To help assure that members have the full range of services they need, MCOs should start with a comprehensive assessment that reviews the physical, cognitive, environmental, social, functional (how well one is able to move about or complete the activities of daily living), and behavioral health aspects of the member. They should also focus on the needs and strengths of the individual and/or family members/caregivers. This record is multi-dimensional and includes member demographics, comprehensive information on the member’s goals, capacities, and physical and behavioral health conditions.

- **Developing a Comprehensive Plan** — Using information from the assessment, MCOs should establish a member-centered plan that meets the member’s needs and goals. The process should include the member, providers and family/caregiver/legal guardian when needed so MCOs can outline and authorize all necessary services. This plan should identify both natural supports and contracted providers. Most importantly, the plan’s goals and objectives reflect the member preferences of services, supports and providers.

- **Providing Service Coordination** — Service coordination is the central, ongoing management of the diverse aspects of member care throughout the acute and post-acute healthcare continuum to achieve the highest quality and most cost-effective outcomes. Service coordination engages members and their families (when needed) in the development of a specific member plan for care, a specific individual service plan, and links the members and their families to other health care and/or services that address the full range of their needs and concerns. Through this process, MCOs should capitalize on existing resources within communities and help assure that members and their families are linked to both formal and informal supports. Service coordinators are the “system navigators” for members and their families and help ensure that members have all the information they need to make personal choices about their care.

- **Providing Transitional Care Management** — Members are at greater risk when their situation or healthcare changes. For this reason, MCOs should use algorithms to identify and monitor critical factors that could indicate a change and manage the inevitable transitions that occur.
Transitional Care Management methods should view transitional care as a set of actions designed to ensure the coordination and continuity of healthcare as members transfer between different locations or different levels of care within the same location (for example: hospitals, sub-acute and post-acute nursing facilities, the member’s home, primary and specialty care offices, assisted living and nursing facilities).

Best Practices

DHH should develop a collaborative model with the MCO that facilitates the sharing of best practices across plans. This will enable the plan to work with DHH on elements such as quality metrics, partnering with providers, enhancing cultural competency among providers, and designing mechanisms to help engage and educate stakeholders and members. We have and continue to develop best practices that overcome barriers to high quality services and supports, take advantage of opportunities to create synergies, and create cross-walks from one aspect of care to another among other things. And they are reflective of the approach we take every day with our members — to offer the best care possible, with the most efficiency possible while creating cost savings for DHH. Below are a few examples of our best practices:

Health Homes/Patient Centered Medical Homes. Since the late 1960s, the concept of the medical or patient-centered medical home has gained support and acceptance as a way to offer members a team of healthcare professionals who provide a single source of comprehensive, continuous care. This allows patients to receive higher quality care. Often, the care team is led by the members’ PCP. By tailoring health homes to meet individual needs, MCOs can help members:

- With multiple chronic medical conditions benefit from a medical home led by a primary care provider (PCP)
- With a severe and persistent mental illness who might require a health home supported by a psychiatrist or psychologist to supplement the PCP relationship
- Who are homebound and need the support of a health home staffed with personnel experienced with long-term services and supports that can optimize the member’s level of functioning and independence

Creating a flexible model helps members with multiple chronic illnesses receive the combination of care that most benefits their healthcare needs. Another benefit of health homes is matching funding. When properly engaged, this effort can essentially garner DHH more money by gaining up to a 90 percent federal funding match. DHH can use those dollars to coordinate and better integrate primary, acute, behavioral health, and long-term services and supports for members enrolled in health homes.
In 2011, Amerigroup Georgia developed health homes with the goal of helping members with diabetes and heart conditions better manage their conditions. After the program’s first nine months, **100 percent of Amerigroup Georgia’s health home members reported they were more confident in their ability to manage their condition in collaboration with the home health physician.** Company-wide there have been similar successes.

**Predictive Modeling.** Informed by significant experience in programming for vulnerable, complex, and high-cost populations such as those needing long-term services and supports, Amerigroup has developed active and ongoing predictive modeling technologies and personnel to help support targeted, appropriate case management approaches. This helps us attain a very high predictability rate of proactively identifying individuals at risk for hospitalization or institutionalization. Focusing first on these cases, which typically include LTSS and dual-eligible members, will help focus the system on its most vulnerable and most costly.

**Provider Partnering.** Amerigroup is a strong proponent of partnering with providers in a variety of ways, including the creation of Amerigroup-supported medical home initiatives, provider incentive programs, and shared-performance programs, which have been embraced by our provider community. Using advanced, high-level technologies is a linchpin for success in these types of partnerships. MCOs need to discuss and receive informed input and direction from DHH on what types of partnering with what types of providers would be most consistent with their vision.

**Interdisciplinary Care Team.** An interdisciplinary Care Team should develop individualized and holistic care/service plans with member, caregiver, and family member input to meet the needs of the member. This multi-member team should consist of clinicians with experience in areas determined by the member’s needs. The case manager in conjunction with the interdisciplinary team should analyze and incorporate member health information to identify specific treatment. The team should then develop and update individual care plans; manage the member’s care; and communicate, coordinate, and monitor execution of all elements of the care/service plan.

**Individualized Care/Service Plans.** A best-in-class health risk assessment tool that measures all aspects of a member’s physical health, behavioral health, social needs, level of functioning, and environmental conditions should form the foundation of the service/care management model. Initial assessments should involve standardized, electronic, comprehensive assessments of the individual’s goals; physical, cognitive, social, environmental, and behavioral health conditions; and needs and strengths of the individual, family, and/or caregiver. This assessment information can then be used to develop a road map to formulate a plan from which to better care for members who require more individualized health care.

**Transitional Care.** MCOs should have a defined action plan designed to ensure the coordination and continuity of care and services when individuals transfer among different locations (such as hospitals, sub-acute, and post-acute nursing facilities; the individual’s home; physician offices; assisted living; and nursing facilities) or different levels of care within the same location. This comprehensive plan should
take into account the individual’s goals, preferences, and clinical status, and it should focus on individual and family education and coordination among the health professionals involved in the transition. The plan should include logistical arrangements such as transportation and respite care; individual education regarding disease states; frequent individual interaction with the case manager and other members of the care team; and education. Housing issues are among the biggest concerns for people who are transitioning from a nursing facility back into the community.

**Quality Management/Measurements.** In addition to traditional acute care quality measures, a quality program for this population should include measures such as program efficiency in containing costs; optimizing community inclusion; client access to services; client centered service planning and delivery; provider access and capabilities; client safety, outcomes, satisfaction, and well-being; emergency room utilization; nursing home admissions; and acute hospital and nursing home readmissions.

The Amerigroup Quality Management (QM) program is fully integrated and encompasses the full spectrum of physical and behavioral health services, including LTSS. We currently provide direct QM oversight of LTSS at our health plans in several states. Amerigroup has the expertise to collect accurate data and competently evaluate measures. Therefore, we propose a collaborative relationship with the State to develop meaningful performance measures that could include:

- Member eligibility and use of services
- Cost
- A focus on functional status measures

**Integrating Behavioral Healthcare**

Amerigroup has vast experience with providing seniors and persons with disabilities (SPD) and dual-eligible members with needed care and validates that both segments of the population — seniors and persons with disabilities — have higher rates of co-morbid physical and behavioral health conditions. We acknowledge and respect the DHH’s established relationship with Magellan Behavioral Health as part of the Louisiana Behavioral Health Partnership. We also understand and appreciate the desire to include this partnership in any Behavioral Health (BH) model moving forward as it seems to offer a platform from which to continue to build BH benefits and services. However, we believe that having two different organizations providing BH care to members fragments the care they receive.

Therefore, **we strongly support the integration of physical and behavioral health services because it is a cornerstone of any program designed to effectively manage this population.** Additionally, since we already provide basic BH benefits and services to members as well as the more subtle BH services provided by the member’s PCP or medical office through routine medical evaluations, shifting inpatient acute psychiatric services currently carved-out would, for us, be a seamless transition for members. We already successfully use this approach in most of our other affiliate state health plans.
In state procurements for MCO participation in an integrated program for SPD members, we recommend that DHH evaluate applicants, in part, based on their ability to integrate physical and behavioral health in day-to-day care management. Successful MCOs should have in-house behavioral health expertise. They should be a supportive partner for the agency and other stakeholders. They should have experience with an integrated case management program based on predictive modeling and risk stratification of both medical and behavioral conditions that combines physical and behavioral health data into ongoing care management.

Other desirable capabilities include co-rounding with both psychiatrists and physical health physicians; and training and coordination programs that pair primary care practitioners and behavioral health clinicians. These kinds of capabilities ensure a truly integrated approach that can optimize treatment and promote continuity of care. It is key for optimal clinical outcomes to manage the individual person, not just the person’s primary medical condition. An integrated program that recognizes how behavioral, social, and functional challenges can compromise an individual’s overall health status (especially in low-income populations) is paramount to delivering improved health outcomes to this population.

**Members are Individuals with Unique Needs**

**Embedding Cultural Competency**

DHH should expect MCOs to offer plans that have a highly developed cultural competency program. It should include a wide range of activities that reduce health disparities and provide meaningful services. They must make sure MCOs understand the importance of cultural norms because it is essential to ensuring members live more successfully in the community.

This helps create an environment that is understanding and sensitive to welcoming and including members in their healthcare and services. It encourages members to fully employ the services offered so they can receive the healthcare and supports they need to reach their personal health and life goals, reinforcing member-centered and self-directed services. In this way, cultural competency becomes a comprehensive, effective tool to address health disparities among members by engaging members early and often. In particular, this approach supports embracing cultural beliefs, preferences, expectations, and norms that influence how and where members access healthcare services and engage with their service and care providers. Focusing on this also helps ensure that members are able to receive, read, and understand healthcare information and member-directed healthcare education aiding them in effectively interacting with their providers.

A broad approach to cultural competency will help embed cultural responsiveness in all practices and customer interactions. Specific requirements to govern such activities should include:

- Developing and managing provider training, networks, and services
- Developing and maintaining a diverse employee workforce
- Developing and implementing care, service delivery, and management programs
- Developing and implementing member and provider outreach and education programs
- Developing, implementing, and maintaining specific cultural requirements
- Developing and maintaining locations where services can be accessed
- Developing and maintaining how members will be educated about cultural competency

To ensure local representation, a local committee/organization can be appointed to guarantee:
- Provider network diversity
- Workforce diversity
- Cultural competency training
- Member outreach and education

To determine the effectiveness of a cultural competency program, DHH can closely monitor member complaints and member satisfaction surveys. And, to make sure the program is in line with DHH goals, policies and procedures can be established and revised as often as the agency deems necessary.

**Service Coordination/Case Management**
Ensuring conflict-free case management should be another tenet of any holistic member-centered approach to care. *We advocate that the MCO manage the case management/service coordination services rather than a third-party vendor or agency.* We believe allowing an MCO to oversee these services creates a far more holistic approach. Plans can be created by a case manager/service coordinator who knows the member and his or her needs and goals, as this manager has access to the whole spectrum of the member’s care and can make care decisions based on that knowledge. The member and case manager are also matched as closely as possible on cultural similarities. Case management/service coordination also allows the MCO to better manage the payment process thus helping ensure that the responsible payer (either Medicaid or Medicare, depending on the services received) is properly billed and reimburses the correct payment for the services rendered. To further safeguard members and DHH, MCOs should not work with any provider who also provides either case management, or functional eligibility assessments as outlined by the Affordable Care Act.

**Education and Outreach**
A strong education and outreach plan is critical to the success of an integrated program for members receiving LTSS services and dual-eligible members. *We recommend both populations be included and an integrated program be created that will involve new ways of delivering services for these populations.* DHH should plan to prepare the various stakeholders using a variety of education methods and forums. The DHH can also include any lessons learned from its experience with other waivers and LTSS programs and incorporate them into the overall outreach plan for maximum effect.

Educating individuals about the program should be done through a number of channels, including local, grassroots efforts through stakeholder involvement. DHH should employ local county social services offices, newspapers and radio, online web-based information, and direct
mail prior to implementation so all media can promote the details of the program in all pertinent languages. This multi-channel approach will help ensure that information reaches individuals with limited access to transportation and/or technology. At roll-out, the agency, in conjunction with the MCOs, should organize informational and enrollment events on all levels, promotional mailings and educational forums for enrollees to learn about the program, their health plan choices, and how the enrollment process will work.

In each parish in the program service area, DHH should identify key stakeholders and hold meetings to educate and explain to them how the program will work. This will allow the agency to present its vision for the program and permit stakeholders to ask questions and get answers from agency officials. Special emphasis should be placed on provider meetings to educate the various provider groups, including doctors, hospitals, home health providers, nursing facilities, and community- and faith-based LTSS providers. The agency should also have town hall meetings to inform individuals, consumer advocacy groups, and organizations about the new program and how to enroll. We recommend that DHH continue stakeholder meetings through the first year of the program to ensure ongoing communications and education. This also gives stakeholders and interested parties an opportunity to provide feedback. It may even be helpful to establish regional advisory committees to perform this function through a formalized structure.

Ongoing community and stakeholder engagement will be important to program’s success and in keeping constituents informed on progress. The agency also should consider contracting with community- and faith-based organizations to assist and supplement its community outreach and educational efforts. Such groups might include:

- PACE
- Centers for Independent Living
- Southwest Louisiana Independence Center
- Southern Care
- Calcasieu for Retarded Citizens
- Point Coupe and Iberville Councils on Aging
- Deaf Action Center of LA
- OPTIONS
- New Horizons
- New Orleans/Baton Rouge Speech and Hearing Center
- United Cerebral Palsy of Greater New Orleans
- Alzheimer’s Services of the Capital Area
- Epilepsy Foundation of Louisiana
- NAMI Louisiana
- Resources for Independent Living
- Advocacy Center
- Kingsley House
- Catholic Charities
It is also essential that providers and stakeholders, particularly nursing facilities, be involved in building the parameters of the program. This is a great opportunity to fully engage and build a solid relationship with these providers and work with them as resource partners. This will help create depth and sustainability and help construct a sturdy, long-term, collaborative investment in DHH and this program. While this won’t happen overnight, we will be there to help develop a program that will serve all its members within the agency’s financial parameters. This approach will provide the agency and its individuals a sustainable, financially sound, expandable program.

**Prior to Implementation**

These community and stakeholder relationships should be established early during program design and maintained throughout the duration of the contract to continually provide oversight and monitoring of the program. A good example of engaging stakeholders early in the development of a new program is the Tennessee CHOICES program. During the initial stakeholder process, the state TennCare program examined a variety of LTSS delivery system options to achieve its overall goal of improving access and choices for individuals needing LTSS. State staff worked with existing MCOs providing managed acute care services through the TennCare program, as well as other stakeholders, to design a program that effectively diverts nursing home placement to an expanded HCBS program. Stakeholders help build strong member protections in the CHOICES program. Tennessee is one of the few states with experience in integrating all services, including behavioral health, into managed care.

Another essential element of effective program design is assuring collaboration and engagement of the provider community. It is in the intersection of quality and cost improvement where DHH can realize the maximum benefits of an integrated program for LTSS members, as well as participating providers and DHH. Through effective provider collaboration, national MCOs with experience managing integrated programs in other states can deploy the experience gained in other markets to bring tested, best practices to positively affect the transformation of healthcare delivery.
Initial Timeframe

The initial timeframe for this program is approximately 10 months from inception to go-live. Amerigroup Louisiana is able to provide this condensed ramp up because we are already in the market and have an established foundation of processes and networks, know the members and their needs, and offer DHH a very well-organized, efficient program. Many elements for this program will need to be fleshed out; however, we will build from our current foundation and hone it to meet the agency’s unique and growing needs. We will need to work on a parallel track with DHH because during this same time frame the agency must submit its application for all appropriate waivers. Figure 2 shows the timeline from inception to go-live.

**Figure 2. Optimal Program Timeline from Inception to Go-Live**

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<tr>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
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<td>• Learn from other states: Texas, New Mexico, Florida, New York, and Tennessee</td>
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Evaluation of Program Success

Evaluating the success of the program should include a quality assessment and a fiscal assessment. A quality evaluation should be based on a number of key success factors, including consumer satisfaction, access to care and meaningful indicators of care integration. Such indicators would include how well the contracted MCO handles discharge planning from an acute setting to ensure that beneficiaries are transitioned to community-based settings whenever appropriate.

Other care quality measures assess the level of integration of Medicaid and Medicare services. For example, DHH should examine the extent to which its MCOs are able to maintain individuals living in home settings with community supports as compared with rates of institutionalization in the FFS environment. Empowering members to remain in the community and in their homes by receiving
necessary and home- and community-based services to delay or prevent nursing home placement reduces acute hospitalizations, nursing facility placements, and duplicative services while providing effective management and care tailored to each level of need. But the most important reason and our impetus for doing this is that many people prefer to be at home. They are happier and experience a better quality of life.

Contractors should also be evaluated on how well they have integrated their internal systems and processes to ensure seamless health care delivery systems for Medicaid and Medicare services. Operational integration should include criteria such as: a single call center, a single member services department, a single complaint system, a single member handbook, etc.

Financial success should be based on hard data. We note that initial data on the program likely would not be available until the program has operated for at least 18 to 24 months. As a result, the success of the program would have to be reviewed after two to three years. Financial success of the program should also be evaluated in terms of savings from the integrated program as compared with baseline costs from the FFS program.

For example, our Texas health plan is an excellent illustration of significant results. For more than 15 years, Amerigroup has provided medically necessary services to Texas Medicaid members and reduced inpatient admissions by 38 percent during the first year of the Texas STAR+PLUS implementation in the expansion areas, even though there was no risk for inpatient services at that time for that program. For the Texas Medicaid population, medical/surgical bed days per 1,000 were reduced by 16 percent from 2009 to 2010, and by 20 percent during a three-year period. Also reduced were the Medicaid Neonatal Intensive Care Unit bed days per 1,000 — by 18 percent from 2009 to 2010, as well as 20 percent during a three-year period. These reductions are the result of Amerigroup's ability to optimize delivery and services for members.

**Funding and Setting Rates**

To most effectively serve Medicaid beneficiaries and taxpayers, *DHH should pursue the cost savings and quality advantages of full-risk, capitated managed care, while maintaining federal Upper Payment Limit (UPL) funds and focusing on the important role they play in the solvency of the safety net.*

However, when states garner these additional UPL funds, their ability to transition to or expand managed care often becomes inadvertently limited, which can prevent DHH from addressing rising medical costs and access to coordinated care. This is the time to explore new policy options that can support a transition or expansion of managed care while preserving UPL monies.

For example, in 2011, Texas was granted a five-year Section 1115 waiver to transition Medicaid beneficiaries into managed care, while retaining the state’s UPL funds. Under the waiver, the funds are deposited into two separate pools — one is a delivery system reform incentive payment program for hospitals and another is a pool for Uncompensated Care (UC). Through the waiver, payments from this component of the pool would help settle the costs of UC provided to individuals who have no source of
third-party coverage for the services provided by hospitals or other providers. During the first year of the waiver, hospitals will also have an opportunity to receive UC and incentive payments that at least equal the same level of funding they received in UPL supplemental payments in the previous year. This approach will help ensure a smooth transition from the existing UPL payment program to the proposed delivery system reform program.

Concerning rates, many use a blended payment for LTSS. When using a blended rate approach, state actuaries develop separate medical cost estimates for individuals who are living in the community and for those living in a nursing facility. These two estimates are then blended into a single estimate based on a forecast of the percentage of members who will be living in the community during the period for which the rates will be effective. Typically, state actuaries will assume that the percentage of individuals living in the community will increase over time. When a blended rate approach is used, the actuaries will develop separate blended rates for dual-eligible individuals and for non-dual individuals. Additionally, as a cautionary note, we have seen that traditional risk adjustment models that are based on the diagnoses of individuals do not work for LTSS services. Diagnosis-based risk adjustment focuses solely on the acute care expenses the individual is likely to incur, not the support services that the individual needs. If DHH were to decide to explore a risk-adjustment process, the decision needs to be based on assessments of the individuals’ functional status, and not on their diagnoses. It should also guarantee rates for a minimum of 12 months so both the MCOs and DHH will have a solid figure from which to calculate costs/risk.

We encourage the agency to pursue this course of action and would work with them to develop and maintain a clear rate strategy. Transparent funding and rate setting processes and specific, DHH-lead guidance on expectations relative to rates will help ensure that cost savings goals support a long-term, sustainable program. With this approach, we can work together on the assumptions, population trends, and calculations for risk and contingency. We have extensive experience in developing medical cost estimates for managed Medicaid programs, and establish appropriate provider reimbursement levels, design risk sharing arrangements and negotiate rates. We will participate fully with DHH to establish principles and create financial arrangements for risk sharing and rate setting that can serve the agency for years to come.

Conclusion

Amerigroup Louisiana envisions a collaborative process for DHH short- and long-term goals and strategies that will help restructure the organization and delivery of Medicaid services to members receiving Medicaid-funded long-term services and supports. We are excited to explore how to best integrate quality, conflict-free case management/service coordination, consistency among Medicaid and Medicare services, and supporting members while they seek out and work toward achieving their healthcare needs and goals. Our experience and current investment in the State of Louisiana will enable us to further streamline healthcare opportunities and address more member needs, while providing best practices and cost-saving strategies. We look forward to furthering our partnership.