Response to State of Louisiana

Bureau of Health Services Financing (Medicaid)
Office of Aging and Adult Services
Office for Citizens with Developmental Disabilities

Request for Information

Long Term Services and Supports for Persons Enrolled in Louisiana Medicaid

January 28, 2013

DEPARTMENT OF HEALTH AND HOSPITALS

WellCare®

January 28, 2013

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Dear Ms. Owen:

WellCare of Louisiana, Inc., (WellCare of Louisiana), is pleased to submit the attached Request for Information (RFI) response to the Louisiana Department of Health and Hospitals for Long Term Services and Supports for Persons Enrolled in Louisiana Medicaid.

Thank you for the opportunity to respond to the RFI. WellCare of Louisiana, Inc. is a wholly-owned indirect subsidiary of WellCare Health Plans, Inc. WellCare provides managed care services exclusively to members of government-sponsored Medicaid, State Children's Health Insurance Programs (CHIP), and Medicare programs, including the frail elderly and adults and children with physical and developmental disabilities. We care for the most vulnerable populations in some of the nation's most challenging states, including urban, rural and island communities.

We appreciate the opportunity to provide assistance to DHH in restructuring the organization and delivery of Medicaid services to individuals receiving Medicaid-funded LTSS and offer recommendations and considerations in the design of the state's future Request for Proposal.

If you have any questions, or require further information, please feel free to contact me.

Sincerely,

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Table of Contents

INTRODUCTION **1**

HAWAI'I EXPERIENCE: 'OHANA HEALTH PLAN AND QUEST EXPANDED ACCESS (QEXA) 1
NEW YORK EXPERIENCE: ADVOCATE AND ADVOCATE COMPLETE MANAGED LONG TERM CARE PLANS 2

POPULATIONS TO BE INCLUDED **2**

BEST ENROLLMENT MODEL FOR THE LOUISIANA LTSS PROGRAM **2**

SUPPORTS AND SERVICES ESSENTIAL TO INCLUDE **4**

APPROACH TO CONFLICT-FREE CASE MANAGEMENT **5**

INCLUSION OF BEHAVIORAL HEALTH **5**

ENSURING TIMELY REFERRALS AND APPROPRIATE FOLLOW-UP 6

EVIDENCE-BASED BEST PRACTICES FOR TREATMENT AND PATIENT CARE **6**

IDENTIFY PARTNERSHIPS **7**

EDUCATION AND OUTREACH PRIOR TO IMPLEMENTATION **7**

ISSUES FOR RFP INCLUSION **8**

CULTURAL COMPETENCY STANDARD **8**

SENSITIVITY TO THE NEEDS OF DUAL ELIGIBLE POPULATION 8

EVALUATION OF SUCCESS **9**

EVALUATING SYSTEM-WIDE PERFORMANCE 9
EVALUATING MLTC PLAN PERFORMANCE 9
LEVERAGING MEDICARE QUALITY IMPROVEMENT REQUIREMENTS 10

FINANCIAL ARRANGEMENTS AND RATE SETTING **11**

PROJECT TIMELINE **11**

RISKS AND BENEFITS **13**

RISKS 13
BENEFITS 14

Introduction

WellCare of Louisiana, Inc. (WellCare of Louisiana) is pleased to submit its response to the Louisiana Department of Health and Hospitals (DHH) request for information regarding the implementation of a coordinated care model for the Medicaid Long Term Services and Supports (LTSS) population. We appreciate the opportunity to provide assistance to DHH in restructuring the organization and delivery of Medicaid services to individuals receiving Medicaid-funded LTSS. WellCare Health Plans Inc. provides managed care services exclusively to members of government-sponsored Medicaid, State Children's Health Insurance Programs (CHIP), and Medicare programs, including the frail elderly and adults and children with physical and developmental disabilities. Our member-centered care approach is designed to meet the needs of these vulnerable populations and our extensive experience delivering services to these populations, makes our organization uniquely qualified to offer recommendations and considerations in the design of the state's future Request for Proposal.

WellCare of Louisiana, Inc. is a wholly-owned indirect subsidiary of WellCare Health Plans, Inc.(herein referred to as WellCare) WellCare cares for the most vulnerable populations in some of the nation's most challenging states, including urban, rural and island communities. We have built a team of associates that engage in member-centered planning, prioritization and operational execution which includes and supports both members as well as their families/caregivers. Specifically, WellCare brings substantial experience in:

- Providing access to physical, behavioral and long-term care services to more than 1.63 million Medicaid beneficiaries in eight states
- Serving more than 90,000 adult, aged, blind and disabled (ABD) and long-term care (LTC) members, all of whom are dually eligible for Medicaid and Medicare
- Operating managed LTC plans in Hawai'i, New York, and most recently, in Florida under the Long Term Community Diversion program in Regions 1 & 2 and Columbia County in Region 3
- Operating Medicare Advantage Coordinated Care plans with approximately 163,000 members in 11 additional states. Of those, more than 67,000 members, are dually eligible for Medicaid and Medicare
- Connecting **all** members and their families/caregivers to social safety net services by cataloguing these services and, when gaps are identified, coordinating community-based solutions to fill those gaps while intricately linking public health and social services to managed care outcomes.

Our considerable success serving Managed Long-term Care (MLTC) members in the States of New York and Hawai'i demonstrates our commitment to serving LTSS recipients and goes beyond the routine. We recognize that taking responsibility for vulnerable members with complex conditions means being ready to do whatever is necessary to ensure their health and well-being.

Hawai'i Experience: 'Ohana Health Plan and QUEST Expanded Access (QExA)

Hawai'i's QUEST Expanded Access (QExA) program is a statewide, mandatory managed care program that provides a comprehensive package of acute, behavioral health, and long-term care services (home and community-based and nursing facility services) to the Supplemental Security Income (SSI) and MLTC population. The program includes a consumer-directed care option similar to what is proposed in Louisiana. Today WellCare's Hawai'i plan, 'Ohana Health Plan ('Ohana), is the larger of the two plans participating in the program, serving approximately 23,000 members including 14,000 Dual Eligibles. 'Ohana also offers a Medicare D-SNP plan.

'Ohana is a clear example of our ability to execute and be accountable for performance. The percentage of members residing in nursing facilities at the time of "go-live" (February 2009) was 54%. From the onset,

providing access to alternative residential housing in order to facilitate successful transitions to the community presented a barrier to providing community based care. Expanding the available capacity of adult family care, adult day health and respite for family caregivers was necessary to demonstrate results. 'Ohana engaged in an array of activities to meet this need. For example, when the 'Ohana team determined that there was a shortage of adult foster care capacity for high need members, the plan developed and implemented a multi-tier payment rate structure that encourages providers to take these members into their homes.

The impact of the 'Ohana plan on our long term care eligible members has been dramatic. Since implementing the program in 2009 the percentage of members residing in nursing facilities reduced from 54% to 41%. This change resulted from 'Ohana's efforts to reshape the long term care system in line with State goals, but also its commitment to every member to achieve his or her highest possible quality of life. As a result of these achievements, 'Ohana Health Plan has been recognized by the Center for Health Care Strategies (CHCS), a nationally recognized health policy think-tank, as innovators in the field of MLTC (Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services).

New York Experience: Advocate and Advocate Complete Managed Long Term Care Plans

WellCare of New York, Inc. serves over 3,600 members receiving managed long-term care services including both adults with physical disabilities and frail elders. Our New York health plan also serves the acute care needs of approximately 4,800 ABD members. In the case of our MLTC members, WellCare is responsible for a comprehensive set of home- and community-based services, institutional care and select acute care services. We provide services to a culturally diverse membership in both urban and rural settings and have considerable experience implementing new services, geographic expansions, and piloting new assessment tools working in close partnership with the NY Department of Health.

Like 'Ohana, this plan coordinates Medicaid covered benefits with Medicare benefits whether delivered through a WellCare Medicare plan, another insurer's Medicare plan or traditional Medicare. WellCare of New York also offers an integrated product that combines a Medicare D-SNP with a Medicaid managed long-term care program for dually eligible beneficiaries qualified to enroll in New York State's Medicaid managed long-term care program.

Populations to be Included

WellCare recommends including all LTSS populations in a capitated, integrated MLTC model. This includes Medicare and Medicaid Dual Eligibles and Medicaid Only recipients who are receiving Acute Care Services, Home and Community Based Services and Facility Services. Including elders, disabled adults, and individuals with intellectual and developmental disabilities is essential to addressing fragmentation in the current system, meet LTC rebalancing objectives, and improve LTSS consumer choices and outcomes. As populations that are excluded from the existing Medicaid managed care system in Louisiana, these vulnerable recipients stand to benefit significantly from a capitated, integrated managed care model with a member-centered approach that effectively links managed care with public health systems and supports.

Best Enrollment Model for the Louisiana LTSS Program

A capitated integrated MLTC model is our recommended strategy to best meet the needs of Louisiana's LTSS recipients, including both Medicaid Only and Dual Eligible populations. A capitated, integrated MLTC model offers a comprehensive managed care solution for Medicaid Only recipients as well as the opportunity to fully integrate care for Dual Eligibles through contracting with Medicare Special Needs Plans, including Dual Eligible Special Needs Plans (DSNPs) and Institutional Special Needs Plans (ISNPs). DSNPs exclusively serve persons dually eligible for Medicare and Medicaid, while ISNPs serve persons living in institutional settings or living in the community with similar needs.

Managed care offers the potential to decrease the fragmentation in service delivery to members with complex needs by addressing and integrating the full range of medical, functional and behavioral needs in a coordinated and member-centric manner. This means putting the member's preferences at the center of the care planning process and leveraging provider resources, in combination with MLTC plan care management technology, comprehensive Quality Improvement Programs (QIP) and integrated telephonic and face-to-face contacts, to ensure every LTSS member receives the services necessary to achieve their short- and long-term goals. We believe implementation of a capitated, integrated MLTC model will allow DHH to: meet the varying and complex needs of all LTSS populations; offer seamless delivery of the full range of medical, functional and behavioral services in a coordinated and member-centric manner; and streamline administrative functions for both individuals and providers.

The following table provides an overview of our recommended enrollment model for the different segments of Louisiana's LTSS population.

Table 1 - Recommended Enrollment Model

	Type(s) of Services	Proposed Model
Medicaid Only LTSS Population	Acute Care Services Only	MLTC Plan
	HCBS or Facility Services and Acute Care Services	MLTC Plan offering ISNP Look-Alike
Dual Eligible LTSS Population	Acute Care Services Only	MLTC Plan integrated with CMS approved DSNP
	HCBS or Facility Services and Acute Care Services	MLTC Plan integrated with CMS approved DSNP/ISNP

For Dual Eligible LTSS recipients, enrollment in a capitated MLTC plan integrated with enrollment in a DSNP or ISNP is recommended. WellCare believes CMS approved DSNPs and ISNPs are uniquely positioned to serve LTSS recipients with complex health care needs by providing patient-centered, coordinated care that is not available in traditional Medicare FFS settings or MA Coordinated Care Plans. In addition, DSNPs and ISNPs meet extensive data collection, reporting, and care management requirements. This includes development of an evidence-based model of care that is subject to rigorous review by CMS and the National Committee for Quality Assurance (NCQA). D-SNPs must also meet additional care management requirements including providing appropriate networks of providers, initial and annual assessments of enrollees, and use of interdisciplinary care teams.

WellCare recommends that all CMS approved DSNPs and ISNPs that operate in Louisiana and meet MLTC plan requirements to deliver Medicaid covered services be offered an integrated contract to serve Louisiana's LTSS recipients. This will ensure effective coordination of benefits for the largest proportion of Medicaid and Medicare enrollees served by these specialized plans. It will also promote choice while preventing disruptions in care for vulnerable LTSS recipients. Through inclusive, rather than exclusive, DSNP and ISNP contracting, the DHH can leverage these sophisticated health plan platforms to significantly increase the level of care management and integration being provided to Louisiana's Dual Eligible LTSS recipients.

For Medicaid Only LTSS recipients, enrollment in a capitated, integrated MLTC model enables one plan to fully coordinate all of the individuals' Medicaid benefits, including both HCBS and facility-based LTSS. For nursing facility and ICF/DD recipients, WellCare recommends developing an ISNP look-a-like model that leverages CMS model of care requirements and provides coordinated and preventative facility-based

care that can improve outcomes and minimize the need for acute-care transfers. For community-based Medicaid Only LTSS recipients, WellCare recommends establishing a chronic condition health home program via Medicaid State Plan Amendment that operates through the MLTC plan. Implementation of an MLTC plan health home program can improve care management and prevent or delay institutionalization for this population while simultaneously drawing down enhanced federal funding.

For all of Louisiana's LTSS populations, the capitated integrated MLTC model focuses on serving individuals in the least restrictive, most cost-effective setting for their individual needs. This includes focusing on effective care transitions when members move between acute care, facility, and community-based settings and providing an inter-disciplinary care team approach. An inter-disciplinary care team approach to case management can comprehensively support MLTC members to ensure they receive necessary services to achieve their individual goals, an essential aspect of LTSS programs.

Finally, as a capitated, integrated MLTC plan, WellCare recommends employing several innovative approaches to delivering LTSS in Lousiana, including:

- **Intregrated Case Management:** Integrated case management and service delivery incorporating key LTSS providers on interdisciplinary care teams. This model leverages the strength and experience of a national managed care organization with the traditional facility and community-based LTSS providers.
- **Community Engagement Centers:** Regional offices co-located with essential community partners to deliver local service in the areas we serve.
- **Long-Term Care Advisory Panels:** Members, facility and community-based LTSS providers and geriatric academic leadership will collaborate with plans to improve quality and leverage best practices.
- **Value Based Contracting:** Providers reimbursed based on quality.
- **Interventions to Reduce Acute Care Transfers (INTERACT):**
  - The INTERACT tool can be adopted for use by network nursing facilities. A patient/caregiver training module can also be developed based on the INTERACT Early Warning Tool that will help members and their caregivers to identify early changes in condition and develop a plan to prevent further exacerbation and mitigate the risk for acute care transfer.
  - Collaborating with geriatricians and other medical specialists to adapt the INTERACT tool for use in community settings in Louisiana and other States.
- **Respecting Choices/Physician Orders for Life Sustaining Treatment (POLST):** Working with partners to facilitate advance care planning conversations.
- **Telemedicine Pharmacy Review:** Collaboration with local partners to conduct medication consultations in the community with Case Managers, members and caregivers.
- **Falls Prevention & Safety:** Collaborating with local Area Agencies on Aging and other community-based providers to launch evidence-based falls management programs.

Supports and Services Essential to Include

A capitated, integrated MLTC model offers the potential to improve the health and quality of life for LTSS recipients by addressing their full range of medical, functional, and behavioral health needs in a coordinated and member-centric manner incorporating both paid and un-paid supports in comprehensive care planning. Under the proposed captitated, integrated MLTC model we recommend including the full array of Medicaid covered services for all LTSS recipients to include acute care services, State Plan LTSS services (including nursing facility and ICF/DD services, personal care services, hospice, and home health care), HCBS waiver

services, and where possible, behavioral health services. By including the full array of Medicaid covered services, both Medicaid only and Dual Eligible LTSS populations can best be served in a coordinated and integrated fashion.

For Dual Eligibles, the most effective coordination of services is possible through an integrated DSNP or ISNP approach described under WellCare's proposed enrollment model. Under the integrated DSNP or ISNP approach, including all Medicaid covered LTSS and State Plan services in the model will create the greateast opportunity for full integration and efficiency in coordinating Medicaid and Medicare services for this vulnerable Dual Eligible population. Where services may need to be carved out of the capitated, integrated MLTC model, the MLTC Case Manager should retain responsibility for coordinating with PCPs, caregivers, community resources and other providers, regardless of whether the services being coordinated are covered by the MLTC plan.

Approach to Conflict-Free Case Management

WellCare recognizes the importance of consumers having freedom of choice of LTSS providers and we support efforts to promote the interests of the LTSS consumer by implementing conflict of interest protections in LTSS systems. WellCare recommends that the DHH build on the existing protections within managed care programs to address conflict free case management requirements in the proposed MLTC model. Our specific recommendations deliver essential consumer protections while attempting to prevent significant disruption to LTSS systems by allowing health plans to partner with experienced community based organizations (CBOs) for both case management and direct service provision. These recommendations also allow for flexibility under the proposed MLTC model to leverage partnerships with an experienced array of CBOs to effectively serve LTSS consumers.

- Within a managed care environment, WellCare believes that existing requirements including freedom of choice documentation, due process activities, and targeted state agency oversight are adequate vehicles to protect consumers from potential conflicts of interest.
- WellCare recommends that Louisiana look to conflict of interest protections, rather than structural changes, to achieve conflict free case management goals.
  - Managed care conflict of interest standards should be developed to enable health plan contracting with experienced community based organizations for the delivery of LTSS services.
- Louisiana should preserve existing economies of scale within their LTSS system to support delivery of Older Americans Act, general revenue, and Medicaid funded LTSS, including case management through CBOs.

Inclusion of Behavioral Health

WellCare supports a fully integrated approach to health services delivery utilizing health plans and integrated primary care platforms to assure coordinated behavioral, primary, and acute care services are delivered to LTSS recipients. Behavioral Health is now widely recognized as an integral component of a holistic approach to health care, but its integration into the health care delivery system remains a persistent challenge. Although DHH has implemented capitated behavioral health solutions for a significant portion of the State's Medicaid population, where possible, we recommend including behavioral health services under the proposed MLTC model. This appears to be possible for facility-based LTSS recipients who are currently excluded from the State's capitated behavioral health care program, and should be considered for all LTSS populations.

To support effective delivery of behavioral health care services to all LTSS recipients, WellCare specifically recommends that DHH:

- Opt for "carve in" approaches to behavioral health programming. This facilitates the coordination of care, as well as the analysis of claims data, so that enrollees with chronic and complex issues can be quickly identified and provided with needed care management services.
- Emphasize data sharing and coordination in "carve out" approaches to facilitate the integration of physical and behavioral health care across the different provider networks.
- Select system level behavioral health performance measures that are carefully constructed and within the span of control of capitated MLTC plans.
- Require needs assessments be conducted by the captiated MLTC plan and not by outside contractors. The MLTC plan can most quickly assess member needs, efficiently connect enrollees with necessary clinicians within the network, and initiate care management or treatment.

Ensuring Timely Referrals and Appropriate Follow-Up

When the need for behavioral health services is identified, the MLTC plan Case Manager should be responsible for making the referral to the appropriate behavioral health resource and coordinating this referral with the member's medical providers. For members who reside in nursing facilities, the MLTC plan case manager can integrate with nursing facility providers for continuity purposes. The MLTC case manager can review member records (including facility Plan of Care, Minimum Data Set, and Pre-admission Screening and Resident Reviews) in order to identify members with existing or new behavioral health needs. The MLTC case manager can serve as a resource to nursing facility staff in terms of behavioral health consultation, and to identify any additional services that may benefit the member. In the proposed MLTC model, the inter-disciplinary care team approach assures that MLTC plan team members with specialized behavioral health training can also be available to support the case.

Evidence-based Best Practices for Treatment and Patient Care

Chronic-disease self-management and other evidence-based programs are an important part of the foundation for a successful capitated, integrated MLTC model. Through enrollment in a MLTC plan, LTSS members benefit from community partnerships that reach beyond agencies/organizations that deliver services or share responsibility for care management. These partnerships can connect members to valuable evidence-based best practices that engage members in the management of their care and chronic conditions.

WellCare recommends that the proposed MLTC plans have the flexibility to select and implement chronic-disease self-management programs and other evidence based disease management programs to meet the specific needs of enrolled LTSS populations. Such programs include, but are not limited to, the National Council on Aging Self-Management Alliance tools, the TEAMcare approach for Patient-Centered Medical Home (PCMH) settings, the Stanford Model for Chronic-Diease Self Management and the IMPACT tool to achieve integrated mental health programming.

WellCare currently partners with associations, academic institutions and foundations to utilize evidence based programming to improve the quality of care for our members. For example, WellCare recently launched a community granting program, and has named the first grant recipient – Texas A&M's Program on Healthy Aging. Texas A&M, WellCare and collaborating partners launched an initiative to conduct outreach, education and research that focuses on helping older populations with chronic diseases to improve and better manage their health. The program uses evidence-based practice protocols based on Stanford University's widely tested Chronic Disease and Diabetes Self-Management Program and serves as an example of how a capitated, integrated MLTC plan can promote evidence-based best practices in serving LTSS recipients.

Identify Partnerships

Community based organizations play a vital role in ensuring an adequate supply of LTSS, and it is important to consider their role in a managed long-term care system. These entities often have long-standing ties with consumers by making LTSS referrals or providing services. Community based organizations are in need of critical support as they operate on highly stretched and thin financial margins. The issues facing community partners and public assistance programs (also known as the social safety net) extend beyond any one stakeholder. Therefore, WellCare recommends that Louisiana require participating plans to implement a robust and highly integrated community engagement strategy that focuses on the sustainability of the network of social safety net programs. In order to support these efforts in other markets, WellCare has established an Advocacy and Community Based Programs department to assess the available social safety net and identify ways to work with local civic and community leaders to offer support. In essence, our goal is to implement a MLTC model that works to provide a safety net to the social safety net.

Using our Advocacy and Community Based Programs model, WellCare can identify gaps in those services across 42 categories within each operating zip code. Once trends are identified, we work to identify solutions that could be implemented with partners appropriate to the scope and size of the issue. Using this approach in Louisiana, we would have the capacity to implement a comprehensive approach to connecting with civic and community leaders among the aging, disability, and developmental disabilities networks including but not limited to:

- Downstream LTSS agencies under the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities
- Faith based organizations like Catholic Charities and New Life Church of God and Christ
- Disaster recovery organizations like local affiliates of FEMA or American Red Cross
- Advocacy organizations like the ARC of Louisiana, the Louisiana Citizens for Action Now.

Education and Outreach Prior to Implementation

WellCare understands that LTSS recipients and providers have not traditionally participated in the managed care environment. For this reason, WellCare employs and recommends that Louisiana implement a very prescriptive approach to provider and member outreach. Founded on the principles of Six Sigma, WellCare uses four phases: Research, Develop, Deploy and Evaluate. This approach is then extended across multiple stakeholders including providers, prospective enrollees or members and other stakeholders.

For members, MLTC plan understanding of the unique care needs and service utilization patterns of transitioning LTSS populations is essential. In addition, State outreach to members to inform them of the transition to a managed LTSS system will be essential to effectively support this population as they enroll in MLTC plans. Member outreach should begin well before enrollment materials are mailed, and for vulnerable LTSS recipients, outreach should be provided in multiple formats to meet individual recipient needs, including phone, in-person, mail, and media approaches.

For providers, effectively training LTSS providers regarding service delivery requirements under a capitated integrated MLTC model should be part of a comprehensive provider outreach plan. WellCare has considerable experience in this area, working with LTSS providers across multiple states to educate them about WellCare and our integrated service delivery model and to partner with many of them to develop inter-disciplinary care teams. Targeted LTSS provider training would encompass:

- MLTC requirements
- WellCare's electronic care management platform
- Credentialing

- Submission for compliant encounters
- How quality outcomes will be measured.

WellCare has developed provider relations teams in multiple markets and it recognizes that initial and on-going provider relations support will be key in assisting the existing LTSS provider community's transition to a managed care system.

Issues for RFP Inclusion

While the DHH may elect to competitively select MLTC plans to serve the Medicaid Only LTSS population, we recommend that the RFP and corresponding DHH policy allow for open contracting with CMS approved DSNPs operating in the State of Louisiana. Under this model, WellCare recommends that DHH allow any DSNP ready, willing and able to meet these state's requirements to participate in the LTSS program. This will streamline State efforts to reduce fragmentation in the existing LTSS system and avoid duplicative or conflicting State requirements. In addition, this inclusive approach would allow the DHH to deliver coordinated, managed care while providing beneficiaries with a real and meaningful choice of providers. Extensive federal requirements exist for both D-SNP and ISNP approval including rigorous model of care reviews.

Cultural Competency Standard

During implementation of the proposed MLTC model, WellCare believes it is essential that all participating organizations demonstrate their compliance and proficiency in the Office of Minority Health National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), including: Culturally Competent Care, Language Access Services and Organizational Supports. In terms of sensitivity to the needs of all members, WellCare recommends a focus on the availability of interpreters (including sign language), extensive staff training, effective coordination with contracted providers and the provider community at large, and, a focused attention on the very complex medical and social needs of Louisiana's LTSS populations.

WellCare provides a wide range of cultural and linguistics services such as free on-site sign language and oral interpreter services upon request and on a proactive basis whenever the need is anticipated by our case managers, video remote interpreting (VRI), which allows interpreters to serve individuals wherever an internet connection exists, TTY or Relay Services and more. WellCare also seeks to recruit staff that are bilingual in English and the other prevalent languages where we enroll significant numbers of members who speak languages other than English. WellCare currently partners with associations, academic institutions and foundations to utilize evidence based programming to improve the quality of care for our members.

WellCare has considerable experience in staff training, including ensuring that member-facing staff members are trained and knowledgeable about how to assist members with limited English proficiency and members who are hearing impaired to obtain an interpreter for all health care purposes, including appointments. This includes training telephone staff to recognize cues that suggest a member may prefer to speak in his or her primary language, even if the member is fluent in English, the use of TDD/TTY devices in order to communicate with our members who are hearing and/or speech impaired and the like.

Sensitivity to the Needs of Dual Eligible Population

One of the strengths of the capitated integrated MLTC model is its capacity for early identification of member needs and ability to offer interventions across the full continuum of care. In many cases, interventions undertaken when service needs are modest, such as offering homemaker and personal care to a member living at home, can forestall the need for more costly services, such as an avoidable hospitalization

or nursing home admission. In this way, the MLTC plan combines member-centric care planning with the resources to help members achieve their short- and long-term goals.

WellCare believes that the model chosen by Louisiana should serve the full range of Dual Eligibles in order to attain the program's full potential. Models that only serve specific populations could easily perpetuate the type of fragmentation that exists today, as beneficiaries would have to change plans, providers, and care coordinators as their needs change. Limiting the program to a smaller segment would also serve to decrease program savings and reduce the size of the dual population that can benefit from care coordination.

Evaluation of Success

For managed LTSS programs thoughtful selection of quality measures and performance benchmarks is critical to monitoring whether MLTC programs are addressing the needs of those being served as well as efficiently and effectively meeting program goals. In September 2011, the American Assocation of Retired Persons, the SCAN Foundation and the Commonwealth Fund produced "Raising Expectations" -A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. In this report is a multidimensional approach to measure state-level performance of LTSS systems that provide assistance to older people and adults with disabilities. The Scorecard examines state performance across four key dimensions of LTSS system performance:

1. Affordability and access
2. Choice of setting and provider
3. Quality of life and quality of care
4. Support for family caregivers.

Evaluating System-Wide Performance

For the purpose of evaluating system-wide MLTC performance, WellCare recommends identifying key dimensions such as those outlined here. WellCare also recommends providing sufficient time for data collection, analysis, and impact prior to evaluating the new MLTC program. Measuring consumer satisfaction close to the start of a new managed care program is likely to represent consumer views on the actual transition from FFS to managed care as opposed to the consumer's experience in the new system of care. Similarly, evaluating the impact of a new system on specific quality outcomes or the balance of institutional and community services typcially requires multi-year data collection to establish a baseline and then analyze results.

Evaluating MLTC Plan Performance

WellCare recommends a multi-prong approach to defining members' health care outcomes and monitoring MLTC plan progress toward achieving these outcomes. We recommend using existing HEDIS measures, additional measures from our Comprehensive Assessment and member centered Plan of Care (POC), and findings from LTSS consumer satisfaction surveys. In tandem, we believe these methodologies provide the best foundation for developing or selecting appropriate quality measures for the proposed captiated, integrated MLTC model.

WellCare recommends that prior to selecting MLTC quality measures or establishing performance benchmarks for proposed quality measures, the DHH should ensure that:

- Nationally recognized metrics are used where available to meet State measurement goals
- Adequate testing and validation of measures have been completed prior to use
- Selected performance measures apply to areas that are within health plan control

- Methodologies behind proposed metrics are publically available at the time of implementation
- Benchmarks are established in collaboration with health plans and other relevant stakeholders
- Adequate display years are used prior to implementation of quality withholds or incentive payments.

We recommend that the DHH look to the approach of the State of Tennessee where the State initially selected performance measures that rely on administrative data such as claims and encounters, rather than metrics that use medical records or clinical extraction. Administrative data also includes data derived from paper records but created in electronic format as is allowed by HEDIS currently.

There is a common understanding that there is a lack of nationally recognized and validated metrics specifically designed for MLTC populations receiving LTSS, although there is significant activity underway to move in that direction. To address the lack of nationally endorsed metrics for LTSS populations, we recommend that policy makers adopt a two-step approach to designing their MLTC quality management framework, relying predominately on existing HEDIS measures in initial years and incorporating additional nationally recognized LTSS metrics in later contract years as they are developed and endorsed. The use of HEDIS metrics can provide a number of benefits to State Medicaid programs. These include:

- Efficiency and flexibility in State use of limited funding for External Quality Review Organization (EQRO) activities. When HEDIS metrics are used, State EQROs can be leveraged to review program performance areas supplemental to those they currently review for the Medicaid program. Under the State of Tennessee CHOICES program where HEDIS metrics are used, the State's EQRO funding is leveraged for health plan network oversight ensuring appropriate access to services and network maintenance by MLTC contractors. This approach minimizes State resources that otherwise would be needed to conduct quality oversight of health plan networks.
- Minimizing the need for State administrative resources and quality related encounter data analysis. Using HEDIS measures that are collected and analyzed through the NCQA health plan accreditation process as well as the Medicare program quality framework can be an effective way for policy makers to meet quality and performance measurement goals while minimizing the need for additional State resources. For States that do not require MLTC plans to be NCQA accredited, they have the ability to contract with NCQA certified HEDIS auditors to perform quality oversight functions. This may benefit States with limited resources for oversight of MLTC program performance. When State policy makers create State specific or home grown measures, significant State or EQRO resources are required to monitor health plan data collection and to analyze measurement results.
- Facilitating comparative analyses across MLTC programs, contractors and populations. It is not possible to make apples to apples comparisons of MLTC program or contractor performance between States or across managed care programs when home grown quality measures and survey tools are applied. Applying select HEDIS metrics to MLTC creates opportunities for State review of health plan performance across programs and populations, including coordinating with acute care quality improvement efforts. This provides a consistent, across the board view of health and wellness.

Leveraging Medicare Quality Improvement Requirements

For the proposed capitated, integrated MLTC program, WellCare sees significant opportunity for policy makers to leverage Medicare program quality improvement activities as part of their MLTC quality management strategy, since the vast majority of LTSS recipients are dually eligible for Medicare and

Medicaid. There are many metrics that exist within both the Medicare Advantage (MA) and Medicare fee-for-service (FFS) settings that measure the quality of care delivered in the Medicare program. This includes but is not limited to; CMS requirements for MA health plans to report HEDIS metrics, quality measures for both nursing home and home health care settings, Medicare Accountable Care Organization quality measures, and extensive quality measurement requirements for MA Special Needs Plans (SNPs). CMS requires SNPs to report two distinct SNP HEDIS measures as well as SNP structure and process measures developed by NCQA and CMS. The SNP Structure and Process measures focus on six areas; Complex Case Management, Improving Member Satisfaction, Clinical Quality Improvements, Care Transitions, Institutional SNP Relationship with Facility, and Coordination of Medicare and Medicaid Coverage. WellCare is eager to improve quality and outcomes for those served in the proposed MLTC program, and we recommend that the DHH leverage these Medicare program quality measures so desired quality improvements can be made in a way that does not add unnecessary additive costs.

Financial Arrangements and Rate Setting

As with the operational design, we encourage the DHH to partner with the capitated, integrated MLTC plans in development of the Medicaid capitation rates. We recommend that the DHH follow a transparent process for rate development that begins with a pre-meeting with potential MLTC plans to discuss the rate setting methodology and to gather their input on what assumptions and methodology will most accurately reflect costs. We then recommend that the State present its proposed rate setting methodology to the MLTC plans, including the data to be used to develop the capitation rates and the trend and other assumptions to be used along with their sources. MLTC plans should receive the managed care factors for fee-for-service data and guidance on how encounter and financial data will be used.

If risk adjustment is to be used (which we recommend with this population), the DHH should provide clear guidelines on how this will be done. The DHH should then provide preliminary rates and give MLTC plans an opportunity to comment on those rates at a face-to-face meeting with the State's consulting actuaries before the final rates are produced. Complete transparency of the capitation rate develop will ensure adequate actuarially sound rates and ultimately, the best possible care for LTSS recipients.

For the LTSS population, the DHH may want to consider establishment of capitation rates that blend per member per month (PMPM) costs for nursing facility residents with members residing at home or in the community, based on a mix that encourages MLTC plans to shift membership away from institutional settings. We support such a methodology in concept, but urge the DHH to pay separate rates for nursing facility and HCBS members for the first two years of the program while the transition to managed care is getting underway. The DHH can still include incentives for rebalancing enrollment through mechanisms such as paying the HCBS rate for the first year a member is in a nursing facility, if the member entered the plan while still in the community. A similar methodology was adopted by Hawaii for its QUEST Expanded Access program and has proven successful.

Project Timeline

WellCare has extensive expertise in managing the transition of populations with special health care needs from fee-for-service to managed care. We have transitioned over 2.3 million Medicaid and Medicare beneficiaries into managed care and have effectively managed transitions for enrollees on an on-going basis. Building from this experience an implementation timeline as well as key MLTC plan implementation tasks is presented in Table 2. This timeline assumes statewide implementation and simultaneous enrollment of all LTSS populations, however the DHH may determine that a phased-in approach would allow for a smoother transition to the capitated, integrated MLTC model.

Table 2 - Project Timeline

Recommended Timeline	Estimated Allotted Time	Comment
Network Development, Credentialing, and System Configuration Example Work Tasks: • Provider Contracting • Provider Credentialing • Provider Contract Load/Configuration • Configure Fee Schedules • Build LOB • Build Plan Codes • Configure Benefits • Build new Ancillary Vendors • Update Customer Service Systems • Receive Enrollment Files (834) • Test	7 Months	One of the advantages of employing a Managed Care Organization is their established provider base, which greatly decreases the time necessary to build an adequate provider system. The State and Managed Care Entities need time to set up IT systems for interoperability, not just with each other, but with the providers and members as well. Payment systems, claims databases, and portals need to be established in order to assure prompt payment.
Provider and Member Education and Outreach Example Work Tasks: • Develop/Mail Member Welcome Packet • Develop/Mail Member Handbook • Develop/Provide Provider Manual • Hold Face to Face Provider Office Visits and Training Sessions • Develop/Distribute Provider Education Materials	4 Months	It is imperative that a block of time is dedicated to integrating members and providers into the managed care environment. This includes provider training and member outreach to reduce Provider and Member abrasion.
Employee Training	1 Month	Training employees is one of the critical tasks in an implementation. For example; it's imperative that Customer Service Representatives are trained appropriately to be able to answer Members and Providers questions correctly and to provide the most accurate information possible.
Readiness Review	1 Month	Prior to any implementation go-live, the operations and processes go through a thorough readiness review phase in which operational processes, policies and procedures, step actions, and employees are assessed to ensure everything is in place to ensure a successful go-live.

Recommended Timeline	Estimated Allotted Time	Comment
Post Go-Live Monitoring	3 Months	After a go-live, the operations of the implementation are assessed and closely monitored for an additional 3-months. This is to ensure as issues and problems arise, they are quickly identified and resolved before they become larger problems. During this phase, metrics are monitored on a daily basis (ex: Call Center Statistics, call drivers from both a Member and Provider perspective, appeals and grievances volume, etc.).

Risks and Benefits

Risks

Fragile Population - By definition, those who receive LTSS include the most vulnerable members of any health care system, which makes thoughtful design and transition to a new system of care essential. While a capitated managed long term care model offers many benefits to streamline fragmented care, the complex care needs posed by this population need to be accounted for in transition policies and dealt with on a case-by-case basis in order to minimize any risk to existing LTSS recipients. We recommend minimizing this risk by fully understanding the demographics and care needs of the included population, implementing standard continuity of care policies for existing LTSS recipients and ensuring provider networks are in place to offer the full array of LTSS services as well as integrated care for dual eligibles.

Provider Managed Care Experience - Currently, there is a provider community in Louisiana that is devoted to serving the Long Term Care population in a non-capitated environment. Outreach to these stakeholders needs to happen at the beginning of the managed care transition process in order to ensure continuity of care and minimal administrative abrasion. We recommend employing a comprehensive change management program targeted to these providers which will ease them into the managed care environment and allow enough time to feel comfortable with the new system prior to implementation.

Community Based Service Providers - Louisiana has a significantly higher institutionalized population than other states. Community based providers will need to be expanded to cover the increased demand for services once the capitated managed long term care model is established. We recommend that implementation plans include sufficient time to establish the expanded community based provider network prior to implementation to assure plans will be able to meet network adequacy standards for the full array of LTSS services.

Economic Impact - Currently there is a fairly significant employment base in the institutionalized health care market. Those same jobs must be available in the community based service sector to minimize any economic impact of transitioning long term care services to a capitated and more community-based MLTC model. We recommend taking this risk into consideration when establishing the community based provider network, including creating a work force development strategy that is tailored to meet the unique needs of Louisiana's recipients and providers. As a State involved in the Money Follows the Person (MFP) Demonstration Program, Louisiana may be able to build off of existing work force development plans that

stem from the existing MFP demonstration. The MFP program funding can be used to pay for continued education training for direct care force workers, and as needed, the DHH can amend the MFP Operational Protocol to align with the proposed capitated, integrated MLTC program.

Lack of Budget or Health Plan Flexibility to Rebalance – The proposed model can help to re-balance Louisiana's LTSS system away from institutional care settings towards community-based settings that are less costly, less restrictive, and in line with consumer preference. However, the ability to re-balance the LTSS system requires both health plan and State budget flexibility in order for the capitated MLTC plans to meet rebalancing goals. We recommend that the DHH develop rate methodologies and program policies for MLTC plans that provide incentives and flexibility to serve individuals in community-settings. To minimize risks associated with budget constraints, we recommend aligning the proposed MLTC model with enhanced match available through programs like Community First Choice, Chronic Condition Health Homes, and if of interest to the State of Louisiana, the Balancing Incentive Program.

Benefits

Budget Predictability – The capitated per-member-per-month MLTC model gives the state budget predictability which is increasingly important as Louisiana faces the difficult challenge of ever growing health care costs and a consistently challenged state budget.

Integration of Care – Managed care systems utilize care coordination as a guiding principle as opposed to the current fee for service system which rewards fragmented care. Integrated care is especially important for LTSS recipients who are often faced with compounding illnesses that need to be monitored by a team of providers. Integrating care through one central location ensures providers and members are on the same page which decreases the use of duplicative services.

Reduction in Inappropriate Utilization Due to Cost Shifting – As managed care plans are single risk bearing entities, they are fully incentivized to employ measures that will improve quality care and reduce inappropriate utilization. Quality incentives could include things like a pay for performance system that focuses on preventive and custodial care and decreases in hospitalizations.

Improved Quality – The use of a single accountable entity that can contract based on performance will provide the state with the ability to move the dial on the quality of care delivered for all LTSS recipients. For Dual Eligibles, inclusive contracting with DSNPs would enable the DHH to leverage CMS required quality data to enhance state oversight of dual eligibles enrolled in DSNP contracts.

Accesses to Care – Managed Care Organizations are required by law to ensure that their provider networks consist of the right types and sufficient numbers of physician specialists. This is a big benefit when tasked with providing health care to a population with complex care needs, and will greatly assist the DHH in improving access to care for Medicaid Only LTSS recipients.

Acuity-Based Resource Allocation – Employing managed care for LTSS services including state plan personal care and HCBS waivers will allow the State to continue its effort to apply uniform assessments and acuity-based resource allocation to these services.