

AETNA BETTER HEALTH[®]

January 24, 2013

Louisiana Department of Health and Hospitals
Attn: Lou Ann Owen
Medicaid Deputy Director
628 N 4th Street, Bienville Building 7th Floor
Baton Rouge, Louisiana 70821-9030

Dear Ms. Owen:

Aetna Better Health is pleased to respond to the State of Louisiana, Department of Health and Hospitals Request for Information (RFI) for Long Term Services and Supports for Persons Enrolled in Louisiana Medicaid. Aetna Better Health recommends a capitated managed care approach for both populations receiving Long Term Services and Supports (LTSS) through Medicaid only and for Dual Eligible (Medicare and Medicaid) recipients through an integrated model of care. Through this integrated approach we have addressed best practices for integrating the delivery of care for LTSS recipients throughout the entire continuum of care that includes acute care, behavioral health, institutional and home and community based and facility services.

Because of the unique characteristics of the LTSS population and Louisiana's high nursing home utilization, coupled with the hospital readmissions among the highest in the nation – all of which pose a significant challenge and opportunity for reduction – we strongly recommend Louisiana release a separate RFP and subsequent contract for managed care organizations to service the dual and non-dual LTSS recipients.

Aetna Better Health recognizes the difficulties of integrating and coordinating care for LTSS recipients including dual eligible individuals, especially since they are likely to be disabled and have a higher rate of serious chronic conditions such as diabetes or pulmonary disease. Dual eligible individuals are a significant cost driver for Medicare and Medicaid. Since Medicaid and Medicare are overseen by different entities, each with its own policies and procedures, dual eligible recipients must navigate a complex system that often involves multiple providers who may be unaware of each other's prescribed services and supports, drugs and diagnoses. We have seen first-hand the impact on the individual and program costs of this fragmented system of care.

We applaud the State of Louisiana, Department of Health and Hospitals for issuing the RFI to further understand how the State can meet its key objectives of restructuring the LTSS program and improve coordination of care and increase quality for LTSS recipients. Please contact Taira Green-Kelley at greent@aetna.com or 573-355-0815 if you have questions or need additional information.

Sincerely,



Pamela Sedmack

Head, Aetna Better Health

Experience

Aetna Better Health, together with its affiliates (Aetna Medicaid), has more than two and a half decades of experience in managing the care of Medicaid populations across the nation. Our fully embedded and integrated medical management capabilities, along with ability to build effective community and provider partnerships and execute strong administrative oversight, culminate in our successful managed care model. We have experience administering benefits and care management for all categories of Medicaid eligible populations, including seniors and individuals with adult onset disabilities, severe and persistent disabilities, individuals with developmental disabilities and the Medicare-Medicaid recipient. Highlights among those we currently serve:

Long Term Service and Supports	Enrollment	Duration of Contract
Arizona (Mercy Care):	9,884	10 Years
Delaware	2,896	Contract began April 2012
Illinois	18,034	Acute care services contract began April of 2011, LTSS services to begin February 2013
Duals	Enrollment	Duration of Contract
Arizona (Mercy Care) Duals SNP:	17,343	6 Years
Delaware	3,230	Contract began April 2012, wrap services only

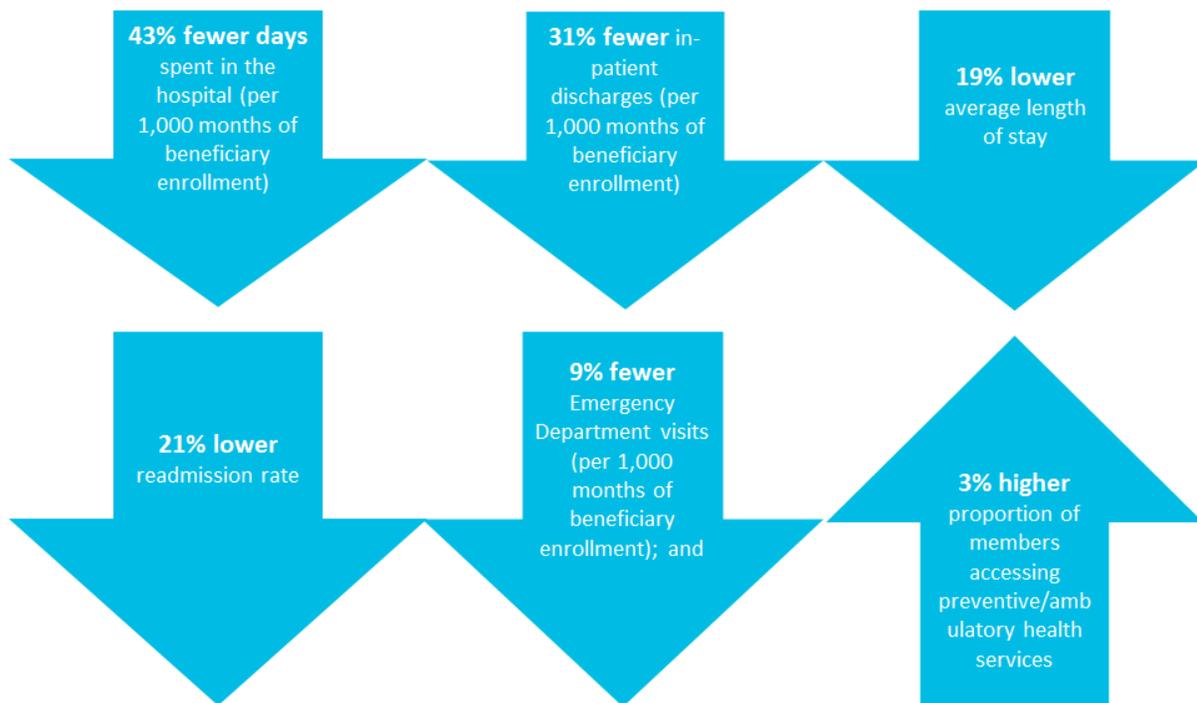
Proven Results: There’s No Place Like Home

Aetna Better Health has established a person centered approach grounded in a recipient’s choice; this is the core of our person-centered care management program. Our LTSS model of care allows for recipients to receive services in the least restrictive setting offering our members choice, while respecting their dignity and ensuring high quality of care. We monitor the overall care plan through an appropriately skilled and professional care manager who works collaboratively with the member and the providers of care. We have arrangements with physicians and nurse practitioners who make home visits to individual homes, assisted living facilities, nursing facilities or can even see our members in community settings like adult day care; these practitioners are members of the individual’s interdisciplinary care team.

This practice approach enabled us to increase and maintain the number of Arizona recipients who receive care in-home settings. In fact, through our work in Arizona since the inception of its LTSS program in 1989 has set the bar high by providing **70% of Long Term Services and Supports in a Home or Community Based Setting, rebalancing institutional care from 90 – 95% for aging and physically disabled recipients residing in nursing facilities, to only 30% currently.** Most importantly, this results in increased satisfaction of our members. Our CAHPS member satisfaction rates have consistently been far and above the 2012 National Committee for Quality Assurance (NCQA) and Centers for the Study of Services (CSS) national averages.

How Our Programs Impacted State Financials

Aetna Better Health recently commissioned an independent third-party to study the results for Mercy Care Advantage (MCA) plan, (an Arizona dual-eligible plan we administer). By providing services in the home setting and improving care where members reside we performed better than Medicare fee-for-service for dual eligible recipients across several key measures including keeping recipients in the least restrictive setting. By seeing members in their home setting for post hospitalization visits, ensuring members got their influenza vaccines and closely monitoring those members with chronic diseases that make them at high risk for hospitalizations, such as diabetes, MCA was successful in decreasing hospital admissions and readmission (see results below). Based on this experience, Aetna Better Health recommends offering in home medical visits options to appropriate LTSS populations regardless of age, disability, dual eligibility or residence (own home, institutional or residential facility). This will increase the effectiveness of the LTSS program and help Louisiana meet its key objectives.



Source: Independent study by Avalere Health LLC

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

- **Populations to be included**

Aetna Better Health recommends a fully integrated, actuarially sound capitated managed care approach for all populations receiving LTSS. Through a fully integrated person-centered approach, recipients who qualify for long term services and supports (LTSS) receive the coordinated care that best meets their individualized needs, while maintaining the ability to reside in the most integrated, least restrictive care setting that supports optimal functioning. This model improves quality of care for the recipient while minimizing the financial risk to the State. The coordination of services and supports provides the best quality of care for the recipient by decreasing fragmentation, recipient confusion and duplication of services.

The guiding principles recommended for an LTSS program include:

- Engage each recipient in their care, while recognizing their strengths and capacities when addressing his or her critical physical, behavioral, environmental and psycho-social needs
- Provide individualized care management, placement, and service delivery based on each individual's needs
- Employ the most effective evidence-based systems as well as appropriate services and supports to create optimal outcomes for the recipient
- Facilitate access to a full continuum of services and supports based upon the unique needs of each recipient to provide the best outcomes possible

Populations to Be Included:

Aetna Better Health recommends DHH include all appropriate LTSS populations regardless of age, disability, dual eligibility or residence (own home, institutional or residential facility). This will increase the effectiveness of the program and help facilitate Louisiana to meet key objectives.

Best enrollment model for program

We recommend the Louisiana LTSS program include a person-centered enrollment model, with **mandatory enrollment** offering a choice of managed care organizations. This benefits recipients, the State and the health plans.

Our experience has shown that mandatory enrollment not only allows for predictable enrollment numbers which is instrumental to managed care organizations in better managing the fragmented care of the recipient, it also best manages the financial risk for the State and benefits the recipient by reducing duplication and fragmentation of services. Having a higher number of managed care recipients provides the critical mass the State needs to attract quality managed care organizations and better enable them to develop larger and more diverse provider networks and a broader array of quality services. Mandatory enrollment also results in predictable state expenditures and budgeting forecasts.

We recommend a phased in approach in the following order of enrollment to help address concerns of advocates:

- | | |
|-------------------------|---|
| Initial Go Live: | The older adults without an I/DD qualifying diagnoses and persons with a physical disability 18 years of age or older |
| After Year One: | Persons with a physical disability under the age of 18 |
| After Year Two: | Persons with I/DD regardless of age |

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

Supports and services essential to include in this model would be many of the core HCBS LTSS currently provided and those pending approval (e.g., habilitation as aquatic therapy, etc.) through the state's 1915(c) waivers. Wherever possible, the state should consolidate 1915(c) waivers to limit differences in the LTSS made available to recipients. With more flexibility on how to design Louisiana's managed LTSS program, the state could administer the managed LTSS program under an 1115 waiver.

Aetna suggests that older adults and persons with physical disabilities have the same array of available HCBS LTSS. The person with I/DD should have the same set of services available to them regardless of age. All LTSS authorized for recipients would need to be determined as medically necessary based on the

recipient's distinct needs and be cost-effective using state specific and managed care organization criteria approved by the state.

Assisted living (residential) services and settings should be made available to those LTSS individuals not needing an institutional setting when it is the best option to meet the recipient's needs. With the challenges to obtaining affordable housing, the availability of assisted living offers not only a better quality of life versus the alternative of living in a nursing facility, but also cost effective. There are many instances where recipients cannot live safely in their own home even with supports, and at the same time they do not need the 24/7 skilled care that is offered by a nursing home or an intermediate care facility.

Our experience has taught us that building a LTSS focused provider network for these vulnerable populations, including older adults and persons with disabilities, is essential to any effective LTSS model. A robust provider network allows LTSS recipients to remain in the least restrictive setting possible while decreasing the need for costly inpatient hospital and nursing facility placements. In addition, it offers choice that enhances quality of life for the LTSS recipient.

Approach to conflict-free case management

All recipients should be provided conflict-free support and coordination through a managed care plan, regardless of where they reside and the LTSS they receive.

We recommend each LTSS recipient have an assigned care manager within the managed care plan to collaborate with the LTSS recipient to provide person-centered conflict-free case management. Through the care manager, the LTSS recipient would have access to an interdisciplinary care team, including the recipient's care manager, other care managers, care management supervisors, behavioral health professionals, social workers, and other health professionals to assist the recipient in goal setting and achieving improved health outcomes. The recipient's primary case manager and interdisciplinary care team should collaborate with the recipient, LTSS providers, physicians/PCP, specialty providers and others as needed to address the recipient's specific individualized needs. Our recommended model is that, the primary case manager and recipient work together to develop a care plan and the case manager arranges for provision of needed services and supports. We ask the recipient to then sign their care plan to acknowledge agreement. In addition, the case manager provides ongoing monitoring to make sure the recipient is receiving the services and supports necessary to safely reside in their residence of choice and to achieve their care plan goals.

When establishing a managed LTSS managed care program the state should consider including routine case management audits/inter-rater reliability to assure consistency in service plan development to best meet recipient needs. In addition the state must appropriately fund care management so that plans can establish the necessary care management to meet the service and support needs of its LTSS recipients and to help the state meet its key objectives in restructuring and rebasing its LTSS programs.

Inclusion of behavioral health

Aetna Better Health recommends the inclusion of behavioral health in a risk-based managed LTSS program. In order to provide quality care and provide recipients with positive outcomes it is imperative that all health care services be included in the array of covered benefits. This would limit care fragmentation for the recipients, reduce duplicative efforts and cost shifting for the plans and state, and promotes efficient and effective use of finite resources. Furthermore, Aetna Better Health's internal data as well as national research shows that behavioral health issues increase medical costs when a recipient's care is separated by physical and behavioral health diagnoses and treated separately for these conditions. Medicaid recipients often face many socio-cultural issues that may become barriers to positive clinical outcomes unless addressed by looking at the recipient as a "whole" person.

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

There are limited evidenced- based best practices and guidelines for LTSS. To counter that, managed care plans will need to ensure compliance with the state requirements to establish plan criteria that is not more restrictive than nor conflicting with state requirements. Plans will also need to establish robust inter-rater reliability programs to ensure case management and other staff that may authorize recommended services are consistently applying LTSS criteria.

The process for adopting guidelines for medical services (non LTSS) should be led by a Quality Oversight Committee to review and adopt the medical clinical practice guidelines and preventive services guidelines. Guidelines should be reviewed at least every two years and be updated as appropriate.

In order to assure that the treatment and care of recipients is consistently provided at all levels, from the care manager to the provider, we recommend that appropriate evidence-based best practices and guidelines are adopted and disseminated from recognized professional sources such as:

- American Diabetes Association (ADA)
- American Heart Association (AHA)
- American College of Cardiology (ACC)
- American College of Physicians (ACP)
- American Psychiatric Association (APA)
- Milliman® Guidelines
- U.S. Preventive Services Task Force (USPSTF)
- Centers for Disease Control and Prevention (CDC).

For review of behavioral health services, we recommend:

- Level Of Care Utilization System® (LOCUS)/ Child& Adolescent Level Of Care Utilization System® (CALOCUS)
- American Society of Addiction Medicine Patient Placement Criteria, Second Edition, Revised® (ASAM PPC-2R)

We also recommend a broad array of other evidence-based, disease-specific recipient and provider materials and communication methods be used to educate, including:

- Krames On-Demand®: contains more than 3000 printable educational sheets on most conditions and diseases.
- Care Considerations: offers provider and recipient messaging (via the Care Managers) on evidence-based treatment recommendations for identified gaps in care related to the recipients' condition.
- MedlinePlus®: a searchable health information database available to our recipients in multiple languages. We provide a link to this database on our website.

Use of Evidenced-based Best Practices and Clinical Practice Guidelines

We encourage the use of clinical guidelines to improve utilization of medications and treatments which are proven to be effective in treating certain conditions. In providing care to the recipient, medical necessity decision making should be supported by using systematically developed evidence-based criteria. Aetna recommends the following medical review criteria to be consulted in the order listed if the specific request is not addressed by that set of criteria:

- Criteria required by applicable state or federal regulatory agency or client contract

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- Pharmacy Clinical Guidelines (for injectable medications only).
- Applicable Milliman Care Guidelines[®] as the primary decision support for most diagnoses and conditions. (If Milliman Care Guidelines[®] state “current role remains uncertain” for the requested service, the next criteria in the hierarchy, Aetna CPBs, should be consulted and utilized.)
- Clinical Policy Bulletins (CPBs) which would be developed especially for the managed care organization
- Clinical Policy Review Unit

Guidelines similar to the Milliman Chronic Care Guidelines should be utilized by care managers as a tool to support the management and education of recipients with chronic multisystem diseases. These guidelines should be updated annually and based on the most current medical research and best practice benchmarks.

Examples of Clinical Practice Guidelines that could be considered:

- Clinical Practice Guideline for Treating Patients with Coronary Artery Disease
- Clinical Practice Guideline for Treating Patients with Diabetes
- Helping Patients Who Drink Too Much
- Clinical Practice Guideline for Treating Patients with Major Depressive Disorder
- Immunizations Guidelines
- Preventive Screenings Guidelines
- Breast Cancer Screening Guidelines

Recipients should have availability to receive general preventive or specific condition-based educational information encouraging them to receive immunizations, screenings, and other services consistent with our evidence-based guidelines and criteria. When deemed appropriate, this information may be shared with network providers.

Identify partnerships that might be formed

Our years of experience in working with Medicaid populations across the nation have taught us the importance of collaborating with locally-based organizations. Provider and advocacy organizations with specialized experience, or expertise in serving Medicaid LTSS populations, are essential to an effective LTSS program. These partnerships work effectively when there is a shared commitment to serving the LTSS recipients.

The state should require all plans establish a consumer advisory council that is made up of recipients, family, caregivers, consumer advocacy organizations and providers. Recipients, families and caregivers should be made up at least 50% of recipients. The consumer advisory council should be one of many venues for the managed care plans to have dialogue on the issues affecting the LTSS recipients and communities. Managed care plans should also be required to actively partner with other LTSS and related organizations so that there can be a better understanding of the LTSS issues in the local community and their impact on recipients. Some examples of community/provider partnerships are highlighted below:

Partnering with Area Agencies on Aging

One such community partnership is illustrated through a relationship we've established with Ohio's Area Agencies on Aging (AAA) to provide assistance with care management activities including completing some face-to-face recipient assessments. Once a recipient is identified and assigned to a level of care management, our staff will work the appropriate professional licensed AAA staff (e.g. RN or Social Worker) to complete a comprehensive assessment using agreed upon tools. This allows for input from the recipient, family members, caregivers, and providers to evaluate each recipient's medical and behavioral health conditions, LTSS, environment and social needs.

Partnering with Health Disability Advocates

Another beneficial partnership in serving LTSS and Aged, Blind and Disabled recipients in Illinois has been with the Illinois Health and Disability Advocates (HDA). From the beginning of the Illinois managed care LTSS program, HDA has been on-site at our managed care organization providing State and population-specific training. This in-depth training has been instrumental in assisting us with keeping abreast of State laws, regulations, socio-economic and cultural sensitivities to better serve our recipients. This relationship continues today, with regular communication and periodic training to help us stay in tune with the receptivity of our program, recipient/stakeholder feedback and any challenges that need to be addressed.

Partnering with Behavioral Health Organizations

To illustrate the success of behavioral health integration, the Aetna Managed Mercy Care Plan (MCP) recognized the challenge of providing integrated behavioral health care in a service area that was new to managed care in Arizona. We worked with the regional behavioral health authority, Community Partnership of Southern Arizona (CPSA), to meet the challenges of behavioral health issues and to build relationships with providers for a more comprehensive delivery system than was previously available. The behavioral health team is now staffed by CPSA and is an integral part of our LTC unit, fully integrated and co-located with our team. The partnership has resulted in specialty case management by a team familiar with local resources and behavioral health needs, a stronger service network and development of new contracts for behavioral health services in the community.

Similar types of relationship may be formed in Louisiana with the Louisiana Area Agencies on Aging (Council on Aging) and/or other organizations like the Louisiana Centers for Independent Living, The ARC of Louisiana, Louisiana Developmental Disabilities Council, The Advocacy Center, Research and Training Center of Community Living, National Alliance of Mental Illness Louisiana and Easter Seals of Louisiana among other organizations servicing the LTSS population.

Education and outreach (for providers, Medicaid recipients, and stakeholders) necessary prior to implementation

In our experience, the following are methods of education and outreach that are integral prior to implementation:

- Similar to the approach conducted by DHH to launch Bayou Health, we recommend holding Community Forums throughout Louisiana to inform and educate all stakeholders. These meetings should allow for public input and question/answer.
- Upon selection of the managed care organizations, we recommend the state conduct another round of stakeholder meetings with participation by the selected plans to introduce the managed care organizations and further educate and inform the interested parties of the program approach and solicit input and feedback.

- Louisiana should require that each selected managed care organization conduct the following series of forums (in person and via webinar):
 - Provider forums to inform and solicit input regarding contracting, out of network requirements, claim submission, and provider expectations.
 - Recipient and stakeholder forums to educate the various advocates including family members on the approach, principles and guidelines.

In addition, we recommend that the selected managed care organizations should be required to establish consumer advisory councils and hold regular meetings to not only drive the education process, but to encourage ongoing communication to allow the plans and providers to clearly comprehend the individualized needs of the recipient population.

Issues DHH should include in any Request for Proposals

- We strongly recommend Louisiana release a separate RFP and subsequent contract for managed care organizations to service the LTSS recipients. The managed care organizations to be considered for a contract award should be required to demonstrate sufficient capacity and should be limited to those that have specific experience serving the needs of not only LTSS recipients, but also the dual population.
- It is important that DHH include network adequacy requirements based on the needs and location of the recipient population. In addition, assure access to Specialized Programs (e.g., ventilator/respiratory, behavioral management, extensive wound management) for these vulnerable populations.
- An RFP should also include clearly defined minimum staffing requirements for care management to ensure that all managed care organizations are consistent and aligned with state expectations and that the program is adequately funded to meet recipient needs and program goals. However we caution that the program should focus on procuring managed care organizations that have best-in-class tools and technology that not only identify, but that have proven innovative approaches for serving the highest utilizers of services.
- Auto-assignment should be based on outcomes after year one, with more favorable results being recognized with an increased auto-assignment percentage.
- All value added services should be actuarially valued and validated by an independent third party for scoring. In addition, value added services should be scored commensurate with the importance they contribute to the recipients care and outcome.
- DHH should support policy that allows managed care organizations to pay 90% of Medicaid to non-participating providers that refuse to contract with the MCO after three good faith attempts.
- The RFP should include a collaborative transition planning requirement so that there will be no gaps in services in transition from fee-for-service to managed care.
- The State should seek approval through formal policy (legislation, regulation or rule) that identifies and states all LTSS recipients to be included in the program. Lack of a formal policy at the on-set for program launch could otherwise prove difficult to add other LTSS populations in the future.

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

Aetna Better Health recognizes the unique characteristics of the Medicaid LTSS population and recommends the following cultural competency standard requirements:

Cultural Competency and Sensitivity

- Training for all managed care organization staff and network providers on preferred terminology and etiquette regarding the target populations such as an older adult or a person with disabilities (ex. “a person who uses a wheelchair” versus “wheelchair bound” and education on speaking directly to a person rather than through a care-giver or interpreter)
- Diversity training for all managed care organization staff and network providers that assists in eliminating barriers to care
- Partnering with recipients and local community organizations to address, in a culturally appropriate manner, the various needs and unique circumstances of the LTSS recipients
- Managed care organizations should conduct an annual evaluation and review, based on feedback, to include a process to gather feedback from recipients, stakeholders, and providers
- Identify lessons learned and identify opportunities to mitigate issues

Developing a cultural competency plan is complex due to the diversity of LTSS recipients. The managed care organization should understand its membership’s needs with special attention to the variance of age, race, gender, disability, and location of residence (rural versus urban, in-home or facility). In addition, a well-developed plan must consider the following characteristics when developing a cultural competency plan for the **dual eligible population**:

- Roughly 1/3 have a physical disability
- 2/3 have mental illness and/or substance abuse issues
- 10 – 15% have intellectual and developmental disabilities
- 2% have Alzheimer’s/Dementia
- 55% having annual incomes below \$10,000 population making the dual eligible population disproportionately lower incomes compared to other Medicare and Medicaid beneficiaries

Accessibility Prior to Enrolling Recipients

- All managed care organizations have an adequate network with physical access to provider offices (wheelchair accessibility, designated parking, and appropriate medical equipment necessary to conduct exams such as elevated exam tables)
- Develop written communication standards that address information written at the 6th grade level and offer that communication in braille, large print, alternative languages and other alternative options
- All managed care organizations must make available and communicate the availability of the RELAY system for the hearing impaired and telephonic translation services
- The State should monitor managed care organization marketing activities and recipient communication to make sure they meet communication and diversity needs of recipients by requiring prior approval of recipient communication materials

Evaluation of success of the delivery model and over what timeframe

We recommend Louisiana evaluate the LTSS program based on the following measures that managed care organizations can monitor to make sure the LTSS delivery model is operating in the most efficient and effective way and consistent with DHH’s goals.

Evaluation of Delivery Model	Timeframe	Relevant DHH Goal
Recipient (CAHPS) Satisfaction Surveys	Annually after 1st year and Every other year thereafter	<ul style="list-style-type: none"> Identifies opportunities to improve quality of services Implement improvements for increased satisfaction and health outcomes Create a system that utilizes proven and/or promising practices
Healthcare Effectiveness of Data and Information Set (HEDIS)	Monthly	<ul style="list-style-type: none"> Improve quality of services and health outcomes Create a system that utilizes proven and/or promising practices
Grievance/Appeals	Quarterly	<ul style="list-style-type: none"> Ensure timelines are met Review opportunities for process improvement Implement processes to improve quality of services and health outcomes when applicable
Access Standards: availability of services, delivery of network adequacy, timely access to care, primary care and coordination/continuity of services	Prior to Program Start Date and Annually thereafter	<ul style="list-style-type: none"> Improve availability and accessibility of quality of services and health outcomes Decrease fragmentation and improve coordination of care Refocus the system in order to increase choice and provide more robust service and living options for those who need LTSS
Inter-rater Reliability evaluations to assure compliance with LTSS requirements	Prior to Program Start Date and Quarterly Thereafter (more frequently if issues identified)	<ul style="list-style-type: none"> Ensure process for continuity in determining medical necessity for LTSS services to provide consistent quality care. Improve quality of services and health outcomes

Evaluation of Delivery Model	Timeframe	Relevant DHH Goal
<p>Evaluating the effectiveness of the program (shifting of balance) by measuring data including:</p> <ul style="list-style-type: none"> • Number of recipients in Home and Community Based Services • Number of recipients in Nursing facility placement • Utilization Management, including Emergency Room and Inpatient utilization • Cost Effectiveness of the program, including cost effectiveness of Home and Community Based services vs. nursing facility services 	<p>After initial one year transition period (program operation) and annually thereafter</p>	<ul style="list-style-type: none"> • Improve quality of services and health outcomes • Refocus the system in order to increase choice and provide more robust living options for those who need LTSS and their families • Rebalance the system in order to meet the growing demand for services within the existing level of expenditures for the LTSS population • Create a system that utilizes proven and/or promising practices • Identify opportunities to minimize financial risk.
<p>Encounter/Claims History</p>	<p>Quarterly</p>	<ul style="list-style-type: none"> • Accurate and timely claims payment • Validate medical cost ratio

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

There are various financial arrangements for sharing risk and rate-setting. Aetna recommends a risk-based arrangement with separate rates calculated for each of the following:

Populations	General Acute Care Recipient	Institutional Recipient	HCBS Recipient
Dual Eligible	X	X	X
Non-Dual Eligible	X	X	X

We recommend the state incentivize managed care organizations in rebalancing institutional placement by continuing to pay the Institutional Member Rate for those recipients moved to HCBS for a period of time such as one year.

We are aware that some states have taken the blended rate approach. However, there are several risks to be considered:

- The blended rate structure creates three types of risk:
 - Selection risk: Risk of a higher than expected proportion of institutionalized recipients as a result of open enrollment
 - New enrollment risk: Risk of a higher-than-expected proportion of institutionalized recipients among the recipients newly enrolling throughout the year

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- Institutionalization risk: Risk of home- and community-based recipients becoming institutionalized at a greater than expected rate
- Network risk: Risk that the nursing home networks of the participating MCOs are not the same, leading to recipient selection bias
- Because of the disparities in medical expenses among the subgroups being blended, the financial results will be sensitive to the recipient mix, i.e. a 1% change in the number of nursing home recipients has a 0.5% impact on claims expense.

It is our experience that movement away from facility placement is approximately 1-2% annually depending on practice patterns and availability of home and community based services. It is important to note that Louisiana may not initially experience this shift from facility to HCBS, so any assumptions in the first year should be conservative.

Timeline necessary for implementation

A realistic timeline would include the following time necessary for implementation:

One Year Prior to Program Start Date:

- Begin stakeholder/recipient/provider communication
- Program development
- RFP release
- Network development

Eight Months Prior to Program Start Date:

- Contract selection with managed care organizations (contract execution at least six months prior to program start date)
- Begin stakeholder/recipient/provider communications (via community forums) in conjunction with awarded MCOs

After Contract Award and Prior to Program Start Date:

- Policies and Procedures Readiness Review
- Network Adequacy Review
- Notification and Enrollment of Members
- Operational Readiness Review (one month prior to program start date)

To facilitate implementation timeliness, we have noted the following interdependencies that significantly increase the timeline if not provided:

- The ability for managed care organizations to obtain complete historical data files from the State is critical to meeting an implementation timeline. The process between requesting historical data files from Louisiana and importing them into production can be challenging and time-consuming because of data-mapping complexities and multiple testing and review cycles
- Requiring a primary point of contact for both the managed care organization and key functions within the State (i.e. information technology, claims, medical management, etc.)
- Meet in person after shortly after contract award and on a regular basis thereafter recurring internal meetings with stakeholders during process to update on progress and challenges

Potential risks and benefits of the approach(es) proposed

Louisiana has a significant opportunity and formidable task ahead in the restructuring and implementation of its LTSS program. The new LTSS program will create several benefits for the state including, but not limited to, meeting the key objectives set forth by DHH to improve the quality of services and health outcomes for Louisiana's LTSS recipients, to decrease fragmentation and improve coordination of care for the most vulnerable of those enrolled in the program. The benefits would include creating a new system that utilizes proven methodologies and program features, to refocus the system and create additional, affordable choices for those who need LTSS. Additional benefits would include rebalancing the system such that Louisiana can meet the growing demand for LTSS decreasing waiting lists, while making sure recipients are in the most-cost effective, least restrict setting possible.

Aetna Better Health believes that to accomplish the key objectives, the state would be best served to partner with managed care organizations (managed care organizations) that have experience managing the LTSS population, which will result in the following benefits to the State of Louisiana and its citizens:

The Benefits: Improved Focus on Health

- At the highest level, all LTSS recipients will be provided more *choice* and a *greater voice* in the new LTSS environment.
- Provide **consistent and accountable quality measures** between managed care organizations that promote and drive improved health outcomes and quality of life for the LTSS population.
- *Measure and demonstrate* quality improvement practices that promote improved health outcomes and quality of life for those enrolled in the LTSS program.
- Drive improved levels of *care coordination* between primary care physicians, specialists, hospitals and LTSS providers.
- Provide direction and establish requirements regarding the discharge process to ensure that LTSS recipients **transition** into effective and appropriate post-inpatient care settings avoiding the need for costly nursing facility services.
- Expanded *network capability* that provides for the additional demand on the LTSS program.
- Improved focus on *prevention and wellness* to ensure that LTSS recipients receive the right level of preventive care to promote improved health outcomes.
- Enhanced *incentives* for recipient compliance with care recommendations and healthy behaviors that will further promote improved health outcomes and quality of life for those enrolled in the new LTSS program.
- Fully **integrated services and support using a person centered care** approach to meet the unique needs of each individual recipient.
- **Decreased duplication of services and supports and less fragmented care** when implementing a fully integrated program for all recipient populations regardless of age/disability.
- **Most cost-effective living options** for recipients requiring LTSS when including assisted living settings.
- **Decreased demand on Nursing Facility services** as network options expand and recipient's needs are met.
- **Increased use of Home and Community Based Services** and expanded HCBS service networks.
- **Decrease avoidable hospital admissions and readmissions**

Managing Potential Risks

Among the potential risks in the success of transitioning the Louisiana Medicaid population from a traditional fee-for-service LTSS program, to a capitated managed care program include:

Recipient concerns. A risk for the Louisiana DHH to be keenly aware of is related to recipient questions and concerns about the impact on their current services and supports and choice in the new LTSS program.

Solution:

- An easy-to-understand recipient communication strategy will be needed to help recipients understand their benefits under the new LTSS program and how it impacts the services and supports they currently receive and their choice of providers.

Community Stakeholder/Organization Relationships. The ability to effectively engage stakeholders to address their concerns regarding the continuation of services under managed care.

Solution:

- Aetna Better Health believes this risk can be mitigated through early and frequent communication between DHH, the managed care organization and the stakeholder groups to discuss the restructuring process and how potential stakeholders may be impacted. Timely communication from DHH and/or the MCO relative to benefit or program changes will also prove beneficial.

Provider reimbursement schedule. Concerns regarding reductions in provider reimbursement levels will be an ongoing issue for the Louisiana DHH to proactively address.

Solution:

- DHH should fund the LTSS program to facilitate adequate reimbursement to providers. Additionally, as stated above DHH should support policy that allows managed care organizations to pay 90% of Medicaid fee-for-service to non-participating providers that refuse to contract with the MCO after three good faith attempts to incentive providers to contract with the MCOs. DHH should continue to leverage its involvement in various provider/caregiver associations (i.e. LHA, LMS, Quality Health Forum, Bayou Health providers) across the state to communicate changes in provider reimbursement strategy. Managed care organizations should also engage these various associations in dialogue.

Lack of Home and Community Based Settings. Since Louisiana leads the nation in nursing home placement, the affordable housing infrastructure and community living environment (Assisted Living) will need to be further developed.

Solution:

- Further develop licensing requirements and infrastructure to support these alternative living requirements. Should also incent Managed Care Organizations to engage in workforce development activities for Home and Community Based providers.

In conclusion, the benefits of moving to a fully capitated integrated managed care program serving all LTSS populations far out-weigh the risks. Over time, the risks can be mitigated with State support, effective partnerships and quality service provisions for recipients. Aetna Better Health looks forward to assisting Louisiana in reaching your goals and improving the quality of life, health outcomes and associated rankings.