



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

RE: Medicaid Long Term Services and Supports RFI

Ms. Owen,

Community Health Solutions of Louisiana (CHS-LA) is pleased to have the opportunity to respond to the State of Louisiana's Medicaid Long Term Services and Supports RFI.

If you require any additional information or clarification as you review CHS-LA's response, please contact me via phone or email as listed below:

Felicity Costin Myers  
(803) 553-2430 – Mobile  
[fmyers@chsamerica.com](mailto:fmyers@chsamerica.com)

Thank you and best regards,

A handwritten signature in blue ink, appearing to read 'Felicity Myers'.

Felicity Costin Myers, Ph.D  
Executive Vice President  
Community Health Solutions of Louisiana



Community *Health* Solutions  
of Louisiana

Medicaid Long Term  
Services and Supports RFI

Presented to



628 N 4<sup>th</sup> Street  
Bienville Building 7<sup>th</sup> Floor (70802)  
Baton Rouge, LA 70821-9508

Presented on

January 28, 2013

Contact Information:

Felicity Costin Myers, Ph.D.

Executive Vice President

(803) 553-2430 – Mobile

fmyers@chsamerica.com

Community Health Solutions of America  
1000 118th Avenue North  
St. Petersburg, Florida  
(800) 514-7621

## Response

Community Health Solutions of Louisiana (CHS-LA) is proposing the following efficient managed care delivery model providing comprehensive, quality of care for acute care, home based, and community based services.

### **Populations to be Included**

This response includes information applicable to the Louisiana Medicare and Medicaid (Dual Eligible) population and individuals enrolled in home and community based waiver programs. Our thoughts address the core elements of an integrated system of care.

### **Best Enrollment Model for Program**

We recommend an enrollment model that uses the Enrollment Broker augmented by community based organization (CBO) partners such as Aging and Disabilities Resource Centers (ADRCs), Louisiana Citizens for Action Now (LaCAN) and Families Helping Families for education, individual counseling and assistance in enrollment. Specifically, we recommend coordination of the system in the following manner:

#### A. Enrollment Broker

Expand Bayou Health services and staff to include a dedicated section within their operations for the long-term care populations. Train Enrollment Counselors on the unique characteristics and benefits of an integrated model and further, the distinctions of the plans awarded this demonstration. This would help ensure that the potential enrollee has access to program materials, educated staff, and assistance designed to educate and guide them through the process of enrollment in a simple fashion.

Enrollment Broker should outreach to identified Eligibles with basic information about the program such as:

- the advantages of an integrated model,
- program implementation date,
- information about plans available,
- how to choose a plan, and
- steps necessary to enroll.

The Enrollment Broker, independently and via the chosen plans, will also make an overview of the program and plan materials available to providers and CBOs that provide services to potential enrollees prior to start-up so that individuals can assess the program and determine the appropriateness for their individual needs.

**Supports and Services  
(Medicaid and non-Medicaid  
funded) Essential to Include  
in the Model**

**B. Community Based Organizations**

Contract with key CBOs to provide enhanced, on-site assistance with enrollment. Ensure staff in CBOs are fully educated on plans so that they can provide the information on choices without bias.

In addition to services currently provided under Medicaid State Plan, Home and Community Based Waiver programs and the state plan for Personal Care Services, we feel it would be essential to include the following:

- 1) A fully integrated care model that assesses and addresses the physical, behavioral, and social needs of the member
- 2) Patient-centered, provider driven, coordinated care that includes the member, PCMH, family and other providers in the development and implementation of an Integrated Care Plan
- 3) A strong focus on data-driven, evidence based care with robust feedback mechanisms regarding patient and practice specific data
- 4) Stakeholder engagement to facilitate understanding and foster smooth program implementation
- 5) Strategic utilization of case management resources through acuity-driven tiered care management which focuses most intense efforts on transitioning care from facilities to community, decreasing length of stay when facility admission is necessary and avoiding readmission into facility-based care
- 6) A Seamless system of care with access to physical health, behavioral health, and long-term supports and services (LTSS) with a consumer direction component
- 7) 8) A provider reimbursement model that rewards the provision of appropriate preventive care and active management of chronic conditions
- 9) A robust provider network that shall facilitate access to community based services and can provide, arrange for, and/or coordinate the full continuum of services for the eligible population including:
  - Primary, Behavioral Health Care and Specialists
  - Hospitals and Institutional care
  - Rehabilitative Services
  - Ancillary supportive care
  - Tele-Health Medicine
- 10) Provider network that meets the standards for provider access in:
  - Federal Medicaid managed care regulations and Medicare access standards for medical services
  - Access to long term care (LTC) services
  - Prescription drugs
- 11) Provider network consisting of providers who are:
  - Experienced with complex geriatric and developmentally disabled populations

- Accepting new Medicaid/Medicare patients
  - Multi-lingual and culturally relevant to their communities
- 12) Compliance with incentives set by State and Federal guidelines for providers to improve health outcomes, including deinstitutionalization
  - 13) Care coordination processes that reduce administration burden
  - 14) Continuum of Medicare and Medicaid services that are fully managed, coordinated and authorized through the MCO and its PCMH including:
    - All physical health services (acute, specialty, and primary)
    - Behavioral health and addictive disorder services
    - LTC services that are covered by either Medicare or Medicaid
    - Integrating services through a comprehensive care plan focused on the whole person
    - Additional services include:
      - PCMH care coordination
      - Multidisciplinary team
      - Comprehensive assessment
      - Behavioral health screening
      - Care plan development
      - Clinical care management
  - 15) Expanded benefits and/or additional support services based on identified needs of Membership
  - 16) Education and Training Program for all program partners
  - 17) Established communication flow for all program partners
  - 18) Robust data sharing and information systems, accessible to all program partners, to promote care coordination, monitoring and quality reporting and facilitates proactive and preventive care management, easy exchange of information, integration of medical, behavioral and LTSS records in a shared electronic medical record
  - 20) Coordination with:
    - Existing Medicaid Waivers
    - PACE Programs
    - Medicare Advantage Plans
    - Other State Payment/Delivery Efforts Underway
    - Other CMS Payment/Delivery Initiatives or Demonstrations
  - 21) Solid infrastructure to include sufficient qualified personnel to provide care in home and community settings
  - 22) Adequate housing and community resources to support the needs of Membership

### **Approach to Conflict-Free Case Management**

Our recommended approach to conflict-free case management is focused on assignment of case managers, based on member and

provider location, who are responsible for developing individualized plans of care based on evaluation of members' goals and physical, psycho-social, functional and environmental factors that are communicated to PCP, specialist and support services to support timely and effective care coordination.

Once engaged in case management, the assigned case manager and support team assist in arranging for services and supports and ensuring the delivery of those services through on-going monitoring. The Care Management entity should utilize a variety of tools to effectively assess and manage members' care. These tools should include, but not be limited to, health risk and disease specific assessments; behavioral health assessments; disease self-management educations; maternity, newborn and infant wellness and prevention education; and evidence based multidisciplinary Care Plans.

Conflict free case management is additionally supported by maintaining a full URAC case management accreditation which addresses conflict of interest and case management ethics compliance.

### ***Inclusion of Behavioral Health***

To ensure appropriate identification of behavioral health conditions, the Care Management vendor should incorporate psycho-social and behavioral health screenings as components of initial assessment with re-evaluation as indicated through on-going monitoring.

When behavioral health needs are identified, care management staff should collaborate with the PCP, Member and, when appropriate, significant others to develop a plan that best meets the individual needs of the Member. A key feature of the PCMH is a team-based care delivery system focused on the needs of the patient and, when appropriate, the family. PCMH focuses on the whole person, so in addition to the PCP and extenders, the care delivery team should include behavioral health providers and others offering support services in the community. Given the reality that behavioral health conditions increase the likelihood of chronic conditions and inconsistent adherence to an established Care Plan and the fact that PCPs are integral in ensuring access to basic behavioral health services, the Care Management vendor should offer telephonic psychiatric consultation to all providers serving the program participants in order to assist them in appropriately addressing the mental health needs of Members.

To ensure adequate behavioral health services are available, the Care Management vendor should contract with behavioral health providers across the continuum of care. Both professional and paraprofessional providers should be engaged to assist members in managing their conditions. Additionally, the Care Management vendor

***How the System Will Use  
Evidence-Based Best  
Practices for Treatment and  
Patient Care***

should develop formal relationships with key advocacy groups to provide support to members and their families. In addition the Care Management vendor should develop a robust tele-psychiatry program to address access issues for members who live in rural areas and/or have mobility issues.

The vendor should utilize clinician decisions through the provision of evidence based criteria that is consistent and reliable. Additionally these guidelines should be designed to recommend treatment guidelines in a variety of settings including rehabilitation facilities and home and should be capable of establishing guidelines for management of chronic disease and behavior health conditions. Evidence based practice by PCMH providers is a problem-solving approach to the delivery of care that incorporates best-practice from well designed and researched studies in combination with a clinicians expertise, Members' preference and environmental considerations. .

Care management staff should be trained on and knowledgeable about available evidence based guidelines and utilize them regularly during the development of individualized care planning and in the evaluation of medical necessity.

***Identify Partnerships That  
Might be Formed***

To adequately support members, it will be essential that the Care Management vendor ensure access to self-help groups and peer support as well as professional services. Potential partners include: American Association of Retired Persons (AARP)

- National Alliance on Mental Illness (NAMI)
- National Empowerment Center
- Partners for Livable Communities
- Advocacy / Self-Management Groups, local and national
- Magellan Behavioral Health
- Alliance for Quality Nursing Home Care
- Louisiana Citizens for Action Now (LaCAN)
- Families Helping Families

**Education and Outreach (for Providers, Medicaid Enrollees, and Stakeholders) Necessary Prior to Implementation**

**Providers:** The vendor should send written materials to applicable providers that will provide an overview of the program as well as detailed information about their proposed approach. Additionally, the vendor should deploy Provider Relations Representatives into provider settings to explain how the program is designed and how the vendor shall establish and operate the program, in an effort to garner provider support and “buy in.”

The vendor should host provider focus meetings in regional locations for the purpose of educating this critical “backbone” of the system/plan and solicit their input on what they will need from the vendor to ensure this program is successful.

The vendor should outreach to rural medical communities through the LA Rural Health Association, LA Primary Care Association, LA Hospital Association and LA Medical Association as well as local community medical societies. The vendor should participate in any and all state-sponsored forums designed to raise awareness of this program. These will include regional, state, and local community settings.

**Enrollees and Stakeholders:** The vendor should assist the Enrollment Broker with development of messaging on program and should provide the Enrollment Broker with brochures and educational materials on program specifics for distribution to potential enrollees.

The vendor should distribute program materials throughout the state in community member outreach events and provide materials and outreach in the following settings:

- ADRCs
- Council on Aging offices
- Disabilities and Special Needs offices
- Provider offices – both Primary Care and Specialists
- Hospitals and hospital-based clinics
- Pharmacies
- Community centers
- Mental health centers
- Alcohol and Other Drug Abuse Treatment Centers
- Local Health Centers
- Churches
- Dental offices
- Transportation providers
- Food banks
- Long-term care facilities

- Adult day care centers
- Other facilities as identified

Additionally, the vendor should continually evaluate program impact through its Quality Improvement and Assessment Program and offer additional evidence based programs based on new research as programs become available, such as current Chronic Disease Outcome grants through the Agency for Healthcare Research and Quality.

***Issues DHH Should Include in any Request for Proposals***

As part of the Request for Proposals (RFP) Response, vendors should address/include:

- How program will promote increased delivery of HCBS services
- Communication plan to bridge gaps across programs and multiple organizations
- Plan for strategic deployment of case management resources
- Tools utilized to provide consistent assessment for population served
- Plan to provide alternative care outside nursing home facilities
- Essential personnel to adequately provide care in home and community setting, including how to expand available resources to meet needs of the population
- Transition planning across care settings
- Quality indicators to track quality of care delivery, health outcomes, member satisfaction and cost reduction
- Oversight mechanisms across care settings
- How standard of care will be evaluated across care settings
- Training Plan to ensure core competencies of all program staff

**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**

With a diverse group of healthcare professionals, including physicians, nurses, pharmacists, specialists, social workers, community liaisons and mental health providers, it is imperative that the most important member of the multidisciplinary Care Team, the member, is at the center of the team. Ensuring that the members' needs are being evaluated, prioritized, and monitored is essential and will be facilitated through active listening and advocacy. To determine and achieve agreed upon patient-centered health goal(s), all members of the multidisciplinary Care Team must be committed to the concept of patient-centered care and the value of input from all Care Team members, must base decisions upon best practices, and provide important information in a timely honest manner using language and terminology that respects the member's culture and health literacy. It is essential that member and caregiver understanding of, and agreement with, all Care Team decisions are assessed prior to implementation.

Upon hire and annually thereafter, care management staff should be required to participate in Cultural Competency education to promote understanding of the diverse health literacy needs of the Membership

**Evaluation of Success of the Delivery Model and Over What Timeframe**

As indicated in the RFI, HCBS programs in Louisiana have performed as well or better than nursing facilities for avoid hospitalizations and HEDIS measures for basic preventive health, and consumer satisfaction. Benchmarks for these measures should be established and additional key performance indicators should be pre-defined and automated reports and dashboards developed. Reporting should include summary and detail to allow for further analysis as indicated by the data, including root cause analysis when trend variations are evident. Reports should be processed and evaluated monthly along with quarterly and annual aggregate results. This will allow for prompt identification and corrective action when indicated. Examples of key performance metrics for project evaluation, in addition to the Physician Dashboard and HEDIS dashboards, described above would include the following:

- Utilization Management Scorecard – trending days per 1000 admissions, re-admission and emergency room utilization
- Access to Care data
- Care Coordination and Case Management Effectiveness Measures
- Certified Patient Centered Medical Home (PCMH) Achievement
- PCMH Health Outcomes (compared to non-PCMH certified providers)
- Member and Provider Satisfaction
- Disease Specific Health Outcomes

**Potential Financial Arrangements for Sharing Risk and Rate-Setting Appropriate for Population; Principles That Should Guide DHH in Requiring Specific Approaches for Rate-Setting**

**Timeline Necessary for Implementation**

**Potential Risks and Benefits of the Approach(es) Proposed**

- Complaint Data
- Healthcare Cost

It is recommended that DHH require the following be included as components of provider reimbursement: 1) withholds which shall be paid out upon achievement of established performance benchmarks. The entire withhold pool should be disbursed to eligible providers; 2) Shared Savings based upon achievement of established performance benchmarks. The pool should be based upon actual MLR.

Rates should be actuarially sound and should include multi-payer funding if possible.

The vendor should utilize a Lean implementation plan to build on existing resources and align strategies for a culture of continuous process improvement with a standardized, disciplined approach that will achieve effective and efficient results. The overarching goal of Lean implementation will be to reduce lead time, reduce variation, eliminate bottlenecks and avoid unnecessary expenditures.

To ensure key elements of implementation are achieved, including organizational structure, deployment methodology, education / training, metrics and readiness assessment, we recommends a minimum of nine months from contract approval date for program implementation.

Potential risks of the proposed approach include, but are not limited to:

- Access to appropriate service level in appropriate service environment
- Availability of qualified personal care service providers
- Silo programs, multiple electronic data systems with multiple providers / programs may impact timely, efficient and effective delivery of program services or delayed identification of improvement opportunities
- Nursing facility support of enhanced home and community based service delivery
- Conflicting program requirements for contracting, enrollment, performance measurement
- Improved provider efficiency through provision of administrative support services
- Community and member awareness of program availability and / or services



Potential benefits of the proposed approach may include, but are not limited to:

- Improved care coordination and delivery in clinically appropriate, cost effective setting
- Enhanced services not currently available
- Improved Member engagement and self-management
- Improved health outcomes and reduced cost
- Job development for state of Louisiana