



DEPARTMENT OF HEALTH
AND HOSPITALS

TRANSFORMING LOUISIANA'S LONG TERM CARE SUPPORTS AND SERVICES SYSTEM

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Focus on Rebalancing
Concept Brief



FEBRUARY 6, 2014

Focus on Rebalancing:

Introduction

As stressed in the initial concept paper released this past August on the transformation of long term supports and services, the ongoing transformation of Louisiana's long-term supports and services system will continue to be an open and collaborative process. The involvement of stakeholders across the state is critical for the successful design and implementation of Managed Long Term Supports and Services (MLTSS) in Louisiana. The purpose of the Long Term Care Advisory Group is to provide an organized venue for feedback from stakeholders in Louisiana, including participants in the current Long Term Supports and Services (LTSS) system, LTSS providers, and community-based organizations involved in the support of those using LTSS. Based on feedback received during the first meeting of the advisory group, future meetings of the advisory group will focus on soliciting purposeful feedback through the use of focused work groups.

Background

The federal Centers for Medicare and Medicaid Services (CMS) has defined "rebalancing" as "reaching more equitable balance between the proportion of total Medicaid long term support expenditures used for institutional services (i.e. nursing facilities and ICFs/DD) and those used for community-based supports under its state plan and waiver options." Under CMS's definition, a balanced long term care system offers individuals a reasonable array of options with adequate choices of community and institutional services, and without a financial and service bias for facility-based services and supports.

As noted in the original DHH Concept Paper, long term care in our state was for many years linked with facility-based care, regardless of the population served. By the early 1990s Louisiana was among the highest states in the number of nursing homes and nursing home residents per capita. The state began the process of

"rebalancing" relatively late compared to many states, but has made considerable progress since 2000 when Louisiana ranked 49th in percentage of spending for community-based vs. institutional long-term care for the elderly and people with disabilities. By 2009, Louisiana's rank had risen to 14th. In terms of people with developmental disabilities, Louisiana's transition from large to small residential settings has happened more slowly than in the rest of the nation. In 2010, Louisiana ranked first in the utilization rate of all Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD). While the number of people with developmental disabilities in residential settings (ICFs/DD) in Louisiana has remained somewhat steady, there has been a shift in the numbers related to size of facility.

However, this trend has slowed in recent years and Louisiana remains below the national average in percent of spending going to community-based versus facility-based care. National and state trends indicate an increasing demand for home and community-based services (HCBS) based on both demographics (aging of society in general and increased longevity of people with developmental disabilities) and legal forces (waiting lists and Olmstead lawsuits). CMS guidance notes that MLTSS programs must comply with the Americans with Disabilities Act (ADA) and the Supreme Court's Olmstead v. L.C. decision. While it is crucial to ensure that high-quality facility services remain available to and viable for individuals when such care is needed, these facts coupled with growing waiting lists (now over 40,000 people) for community-based services points to the need for continued rebalancing of Louisiana's LTSS system.

Feedback to Louisiana's Approach

As DHH continues to research best practices and lessons learned from other states and works to build the framework for the transformation to MLTSS, DHH is actively soliciting feedback on the following areas:

Focus on Rebalancing

MLTSS has shown great success in rebalancing in other states. Arizona, Minnesota, New Mexico, Tennessee and Wisconsin all report either shifts in spending toward the community, more persons receiving services in the community, and/or reduction or elimination of waiting lists for community-based services. A number of issues already discussed by the work groups have implications for rebalancing and the recommendations are consistent with a rebalancing goal. For example:

- ▶ Benefit design should include both home and community-based services (HCBS) and institutional services.
- ▶ Plans should be empowered to provide a wide array of services that support community based settings.
- ▶ Care coordination should cover all populations, including those in facilities, and should include an emphasis on transitions management between facilities and the community.

RATE STRUCTURES

CMS guidance notes that MLTSS programs should have rate structures that support the program goals. Given the demand-driven and legally mandated need to continue rebalancing efforts, CMS notes that “In keeping with the intent of the ADA and Olmstead decision, payment structures must encourage the delivery of community based care and not provide disincentives, intended or not, for the provision of services in home and community based settings. For example, inclusion of both institutional and non-institutional services in a managed care capitation rate provides plans with the flexibility to offer lower cost non-institutional services to beneficiaries and support system rebalancing towards greater use of non-institutional LTSS.”

State approaches to achieving this goal may vary based on the state’s situation and/or the population covered. A widely used and recommended practice in many states, especially in programs serving persons with aged-related and adult-onset disabilities, is the use of a “blended” rate. That means the per member per month (PMPM) payment to MCOs pays less than the full cost of care

of a person in a facility in the fee-for-service system but more than the cost of a person in community-based services in the fee-for-service system. Another frequent practice is that while the PMPM is blended, rates paid to providers are either set by the state or the state at least establishes a minimum rate or rate floor. Such a payment system ensures individual providers are adequately compensated, while at the same time giving the at-risk MCO incentive to provide care in the lower cost community-based settings where such is consistent with the health, welfare, and quality of life of the individual.

States that do not use blended rates have other means of encouraging rebalancing. Massachusetts, for example, pays plans a lower rate than the standard nursing home rate for 90 days after a participant enters a facility. But if a participant transitions from the facility to the community, the state plays the higher facility rate for 90 days after transition. This provides a financial incentive to try to return persons to the community when feasible. Minnesota pays an add-on supplement based on projected facility use, but stops the payment when a participant actually enters a facility.

Evidence indicates that there are a number of ways to develop a rate structure that ensures adequate reimbursement while providing the right incentives to support rebalancing. Given that Louisiana has differences in the relative costs of community versus facility care between the two major populations receiving LTSS, the two procurements may require different rate structures and types of incentives. However, each should be designed to encourage rebalancing.

COORDINATION WITH CMS INITIATIVES

Managed LTSS in other states is being successfully coordinated with initiatives like Money Follows the Person (MFP) and the Balancing Incentive Program (BIP) to aid in rebalancing. Louisiana is participating in both these initiatives. Money Follows the Person provides enhanced federal reimbursement for HCBS services to participants who transition from a facility into the community. The Balancing Incentive Program provides enhanced federal reimbursement for certain HCBS services, provided the state achieves certain rebalancing goals.

Together these initiatives have great potential for addressing the demand for community based services and providing an opportunity for providers to diversify, while also providing enhanced funding to the state. DHH believes plan participation in the goals of MFP and BIP, as well as CMS maintenance of effort requirements, should be explicit in the RFP, and plans should be asked to describe their approach along with any evidence of effectiveness.

OTHER REBALANCING ISSUES AND METHODS

Many states include in the MLTSS system the use of incentive payments, sometimes using funds from MFP or BIP, to achieve greater rebalancing and/or wait list reduction. Some states also apply penalties to MCOs that fail to achieve rebalancing goals. DHH supports the use of either or both methods.

Yet another method for supporting rebalancing used by some states, including Tennessee, is to cover short-term facility stays as part of the community-based service package. This allows participants who need short-term stays to retain more income and resources and thus facilitates return to the community.

DHH also believes that savings achieved through rebalancing should be invested in services and initiatives that facilitate rebalancing, incentivize rebalancing, address gaps on the community service

system that pose a barrier to rebalancing, encourage institutional diversification, and, if relevant, address wait list reduction. MCOs should routinely report on service gaps and other barriers to rebalancing and propose strategies to address these. System rebalancing and, if relevant, wait list reduction, should be key measures in assessing and rewarding plan performance.

Louisiana's Approach to Rebalancing: Workgroup Questions

- 1. This paper mentions several methods for achieving rebalancing goals within MLTSS:**
 - a. Designing rate structures which incentivize rebalancing,**
 - b. Continuing to participate in CMS initiatives such as MFP and BIP,**
 - c. Providing financial incentives or assessing financial penalties for plans that fail to meet rebalancing goals.**
 - d. Do you support use of these methods?**
- 2. Are there other suggestions you have for encouraging rebalancing?**
- 3. How should any savings from rebalancing be used?**

Transforming Louisiana's Long Term Care Supports and Services System

*For additional information, please visit
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