LEADING TRANSFORMATION:

Our FY 2012 Priorities for a Healthier Louisiana

DEPARTMENT OF HEALTH
AND HOSPITALS

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Message from Secretary Bruce D. Greenstein

Dear Friends:

A well-performing government, at every level, is an important part of a successful society. Where failure has occurred is when public institutions begin counting success as simply continuing to exist. The world is changing, particularly around health care. We cannot afford to just exist and churn out the same processes and outcomes of each previous year. We believe in Louisiana's potential. In particular, I believe in this agency's potential to be a catalyst for better health. Through smarter management, executable work plans, measurable goals and consistent accountability, we can begin to change the way that health care is financed and delivered in our state.

The Louisiana Department of Health and Hospitals (DHH) is an $8 billion enterprise with close to 9,000 employees. We have service lines and responsibilities that stretch across the health and health care spectrum. While it is an organization filled with dedicated people, we have lacked the structure to plan executable goals and effectively measure and manage our progress. I do not pretend that this business plan alone will solve our state's health challenges. What it does say — and I think this is incredibly important — is that the government agency charged with the mission of protecting and promoting the health of the people of this state is, in many areas, challenging the notion of "business as usual." I invite you to examine the plan thoroughly. Within, you will find a thoughtful analysis of our state's current health status, including both the challenges and opportunities we have before us. We'll explore DHH's current impact as the state's health care agency, including a business review of our critical functions and an honest look at our performance. The heart of this plan is a detailed description of the department's top policy and programmatic priorities for health care.

These 20 Transformational Priorities are our "big bets." Through these priorities and commitments, DHH is holding itself accountable for the execution of the responsibilities bestowed upon us by people of this state. We pledge to ensure that we are spending the dollars that you, the taxpayer, have entrusted to us with the highest levels of integrity, efficiency and effectiveness. It is no secret that our state lags in many health rankings and indicators, but we should not accept 49th place in perpetuity. Our potential is so much more and we will only achieve success by working together and taking responsibility.

Warm regards,

Executive Summary

Louisiana faces numerous challenges when it comes to improving our health care system. However, the successes of both the current system and the Department's efforts during the past year are noteworthy. The FY 2011 business plan was the first of its kind for DHH. Its publication was the first step in an effort to introduce a predictable rhythm into the business cycle of the department. DHH leadership has used it as a guide and accountability tool to ensure that the day-to-day work is aligned with the priorities set forth. Department leadership gathered in February to conduct mid-year review sessions to measure progress and set goals for year-end close-outs.

Goals that carried forward from the FY 2011 plan include a continued effort to streamline operations, improve services, measure outcomes, ensure efficient spending and implement community-based expansion. From these themes emerged Transformational Priorities that represent those priorities with the highest potential impact.

These transformation initiatives are grouped into three major areas and represent the Department's focus in 2012. While they don't represent the full book of business of the department, the goal within this business plan is to present the Department's top priorities. Others will emerge throughout the year, and DHH leadership encourages residents and stakeholders to respond with their own big ideas and priorities for health care in Louisiana today.

The three themes guiding the Department's work are:

- ✓Building Foundational Change for Better Health Outcomes
- ✓Promoting Independence through Community-based Care
- ✓Managing Smarter for Better Performance

Building Foundational Change for Better Health Outcomes

Because of the significant challenges Louisiana faces in health outcomes and the health status of its citizens, it is no surprise that the largest section of this business plan is around rebuilding systems that challenge the status quo with a laser-like focus on improving health outcomes.

The nine initiatives under this theme are all about making significant change, not merely tinkering around the edges. All are already underway in some form or another, and the deliverables set under each one represent the critical phases of implementation this fiscal year. They are:

- Medicaid Coordinated Care Network (CCN) Program
- Louisiana's Vision for Health Information Technology
- Greater New Orleans Community Health Connection (GNOCHC Clinics)
- Medicaid Management Information System (MMIS)
- Louisiana Behavioral Health Partnership (LBHP)
- Coordinated System of Care (CSoC)
- Integrating Behavioral Health Business Practices and Treatment Approaches
- Integrating Public Health and Primary Care
- Louisiana Birth Outcomes Project

Promoting Independence through Community-Based Care

For decades, institutional care has been the predominant approach to long-term care services in Louisiana. In recent years, the Department has been setting up the infrastructure and value structure to provide citizens with developmental disabilities as well as the aging population more robust independent living options.

Each of the priorities in this theme carries that work to the next level with a detailed plan for making these transitions sustainable and more robust with increased options and supports. They are:

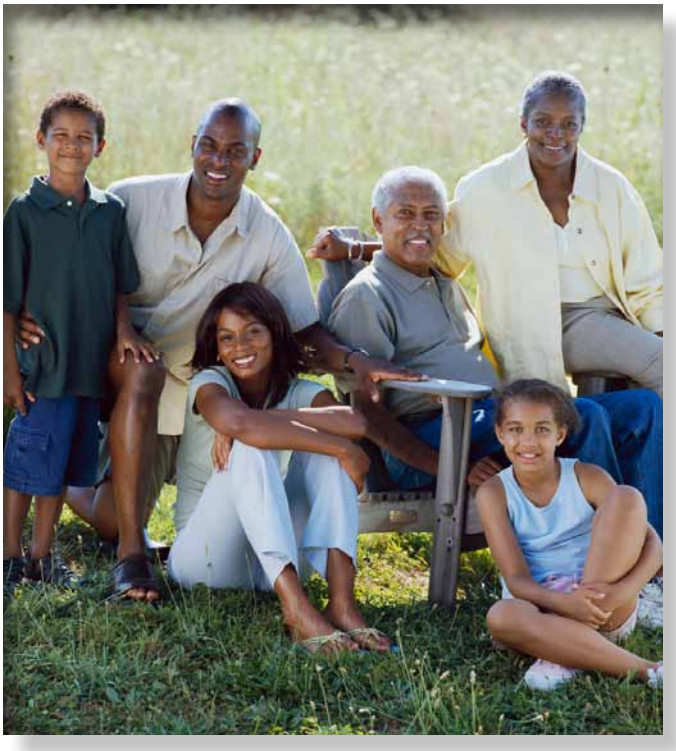
- Redesigning the Community-Based Long-Term Care Infrastructure
- Right Balancing Institutional and Community-Based Long-Term Care

- Employment First Initiative for Citizens with Developmental Disabilities
- Sustainable Home- and Community-Based Supports and Services
- Systems Rebalancing for People with Developmental Disabilities
- Strengthening the Home- and Community-Based Infrastructure

Managing Smarter for Better Performance

With a budget of $8.2 billion and a work force of nearly 9,000 employees, managing smart with accountability and transparency is a hallmark priority for the Department. Each of the priorities in this theme is focused on improving services to constituents, using technology more effectively or protecting precious taxpayer resources. They are:

- Louisiana Electronic Event Registration System (LEERS)
- Louisiana's Disaster Data Collection System for Health Care Facilities- EMSTAT
- Combatting Fraud and Abuse
- Eat Safe Louisiana
- DHH Information Technology



HEALTH CARE IN LOUISIANA TODAY

Louisiana has a long history of health challenges that persist today. These challenges are illustrated in countless studies. Most commonly cited ones such as the United Health Foundation, the Commonwealth Fund and the Annie E. Casey Foundation all placed Louisiana 49th in their most recent overall health rankings. There are a number of factors that make up that ranking – some as far reaching as levels of poverty and education and some more closely aligned to the state's health care system and direct health outcomes.

For the past three years, the Department has made significant and foundational changes to begin the long process of improving the health outcomes for the people of Louisiana. Significant challenges remain, but the road to improving those is being paved with a series of initiatives – many of which are already seeing improved outcomes and many more of which are outlined in the pages of this business plan.

Those initiatives already under way have increased access to care for all residents, especially children; enhanced accountability and transparency; and are transforming the provision of health care services to a more efficient and effective system that puts people first and bureaucracies last.

Increasing access

The role of health insurance coverage and access to care cannot be overlooked when considering health outcomes. Whole coverage doesn't always translate to access; we know that it is one of many factors that must be considered because the ability to access preventive care is proven to head off chronic conditions that haunt many Louisiana residents. It's also one factor the state has seen significant improvements in during recent years. From 2007 to 2009, the number of uninsured children and adults in Louisiana has been on a steady decline, according to the 2009 Louisiana Health Insurance Survey (LHIS). The number of uninsured children and adults in Louisiana has declined to 5 percent and 20.1 percent, respectively. While this success is noteworthy, Louisianians, like residents in

states across the country, continue to experience disparities and inequalities in access to insurance based on race, income, education, and age.

One approach already under way and outlined further in the Transformational Priorities section of this business plan to address these disparities is the Greater New Orleans Community Health Connection (GNOCHC). The Department has worked with local and federal officials to sustain a network of primary and behavioral health care clinics that grew organically in the aftermath of Hurricane Katrina in the four-parish greater New Orleans metropolitan area. The GNOCHC initiative provides primary health care services through 39 primary and behavioral health clinics operated by 19 organizations. This innovative model can serve as an example for the rest of the state and country as leaders look to expand access to integrated community-based primary care settings.

And it's not just in the New Orleans area. The state has made investments in primary and preventive care clinics statewide with 17 new rural health clinics certified since Jan. 1, 2008, and 41 new federally qualified health centers.

DHH also helped local governments, hospitals and other health care providers maximize health care dollars and preserve access to care for Medicaid patients through a series of new "Upper Payment Limit" (UPL) programs that will be expanded in the coming fiscal year. Already, these programs have established public-private hospitals partnerships to provide health care services to the poor and needy, resulting in $195.9 million additional funds to 28 hospitals across the state. In July, Gov. Bobby Jindal signed HB1, which provides more than $102 million in expenditure authority for DHH to pay local public hospitals and ambulance services through the UPL programs in FY 2012.

Transforming the health care delivery systems

Again, we know through countless studies that having an insurance card or Medicaid coverage alone does not guarantee access nor improved health outcomes. For instance, 29 percent of Louisiana's population (about 1.2 million people) obtains health care coverage through the Medicaid program that, despite spending nearly $7 billion (more than $2 billion in state funds) a year, has generally shown little, if any, improvement in health outcomes for its enrollees.

While the American Cancer Society notes that Louisiana has among the highest rates of breast cancer deaths in the United States, only 40 percent of eligible Medicaid women were screened last year for the deadly disease. Only 56 percent of eligible Medicaid women received recommended cervical cancer screening and, in fact, fewer than 10 percent of adults in the Medicaid program even had a preventive visit last year. Despite rates of diabetes among adults having nearly doubled from 1997 to 2007 (5.2 percent to 10.1 percent), only 66 percent of Medicaid-covered diabetics tested their blood sugar level in 2008

After decades of running a fee-for-service Medicaid system that focuses on volume over value, the state is implementing Coordinated Care Networks (CCNs) across the state in FY 2012. The primary objective of the reform is to improve health outcomes – a result seen in other states that have embarked on similar Medicaid coordinated care initiatives. By better managing chronic and costly conditions, DHH expects a reduction in some of the more costly health care services such as unnecessary hospitalizations and emergency room visits. In addition to improving health outcomes, CCNs are expected to save $135 million in the first full year of implementation. You can read more about CCNs in the Transformational Priorities section of this document.

In similar fashion, DHH is launching a comprehensive redesign of Louisiana's behavioral health system to improve coordination and access to mental health care and addictive disorders treatment. The Louisiana Behavioral Health Partnership (LBHP) is a new approach to the delivery and financing of behavioral health services to Louisiana's children and adults through an integrated public behavioral health system that draws on the strengths of the public and private sectors. Like CCNs, the concept of the Partnership is to focus services and care on quality rather than simply paying for quantity. As part of the Louisiana Behavioral Health Partnership, DHH is working jointly with three other state agencies to implement

a Coordinated System of Care (CSoC) for youth with significant behavioral health needs that will improve coordination across multiple agencies so that children and families receive one plan of care that more effectively organizes resources and better leverages state funding. You can read more about the Partnership and CSoC in Transformational Priorities section of this document.

These two initiatives are just the next logical step in a transformation that has been occurring in behavioral health for the past several years in Louisiana. Historically, the state has relied heavily on the Disproportionate Share Hospital (DSH) Program to fund behavioral health care. The perverse incentives of the DSH Program, which has also historically been used to fund the state's public hospital safety net system, forces people into institutional settings, whether it's accessing care through emergency rooms or into large state-run in-patient psychiatric settings. This has created a bias toward institutional care that has kept money from primary and preventive care.

But, this has been changing. The state has been shifting dollars and enhancing community-based services that allow people to stay with their families and in their communities. In the past three years, this transition has allowed an additional 2,725 individuals with behavioral health care needs to receive services and access private community-run options rather than the large state-run institutional setting.

Among the safety net hospitals, the state has also entered into a historic agreement establishing a public/private partnership between LSU's Earl K. Long and Our Lady of the Lake in Baton Rouge to leverage private resources to serve the underserved while also enhancing academic medical opportunities.

Like the effort to enhance community-based options for people with behavioral health needs, DHH's Office for Citizens with Developmental Disabilities has continued to pursue policies that promote the most integrated setting appropriate to the needs of Louisiana residents with developmental disabilities. In FY 2011, continued implementation of resource allocation polices that establishes an individual budget based on needs has netted an estimated plan savings of more than $26.5 million, while also empowering individuals to live fuller lives more integrated into their communities. Further, DHH has worked to close, consolidate, downsize or transition to private management state-run community homes and public supports and services centers. Last fiscal year saw the successful closure of one large and one small center and 14 community homes, of which three community homes converted to flexible waiver services and five which served people with complex medical needs privatized through cooperative endeavor agreements. Additionally, one center privatized through a cooperative endeavor agreement. These policies have been coupled with person-driven planning and careful individual assessment of current center residents to determine appropriate cases for transition to community-based settings. In FY 2011, DHH successfully transitioned 302 individuals from institutional to community settings, providing greater opportunities to be a part of everyday activities that we all enjoy, such as family relations, community engagement, work options and cultural enrichment to build better quality of life.

One of the most difficult statistics in Louisiana's health care outcomes is around infant mortality and prematurity. Louisiana ranks 48th in infant mortality according to the United Health Foundation (UHF). The UHF report card for Louisiana shows that 11.2 percent of infants in Louisiana were born at a low birth weight and 16.6 percent of births were under 37 weeks gestation. Because the state pays for about 70 percent of the births in Louisiana, in addition to the heavy toll these often-preventable outcomes place on families and communities, they also cost state taxpayers as much as $200 million annually. To address this situation, in 2010, DHH announced the beginnings of the Birth Outcomes Initiative. One key component of the program is to end the delivery of infants before the 39th week of gestation unless medically necessary. On July 13, 2011, DHH Secretary Greenstein announced the commitment of 20 Louisiana hospitals to DHH's 39-Week Initiative. Since then, an additional two hospitals have signed onto the pledge. As part of this initiative, DHH also expanded tobacco screening for eligible pregnant women and made

available for the first time to Medicaid covered moms, a life-saving drug proven to prevent repeat preterm births.

Enhancing accountability and transparency

Since late summer 2010, the Department has expanded its efforts to reach out to health care providers, consumers, taxpayers and communities across the state to seek fresh ideas and feedback on programs and policies, as well as share greater amounts of information about the Department's efforts to improve health and health care across the state. Whether through an aggressive new media program or community meetings, the Department has initiated a new approach to achieve greater transparency and interaction with those impacted most by its daily functions and decision making.

Even before then, the State launched a Consumer Right to Know initiative that is providing quality data for a number of different types of providers at the healthfinder.la.gov website. This first-of-its-kind initiative gives consumers information they need to make informed decisions about nursing homes, hospitals and a host of other care providers. It also introduces accountability for those providers by making quality results public. More recently, DHH launched the EatSafe.La.Gov website that gives residents food safety information and open access to the inspections DHH sanitarians conduct of every retail food establishment in the state.

For critical transformational overhauls such as Coordinated Care Networks in Medicaid and the Louisiana Behavioral Health Partnership, the Department and its leadership have held more than 20 community forums across the state to provide information, engage in an in-depth discussion and offer answers to questions from providers, consumers and advocates. These two transformations are fundamentally altering and improving the way Louisiana is administering Medicaid and behavioral health services and thus created many questions, much discussion and debate and, most importantly, an opportunity for consumers, providers, policy makers and advocates to have a constructive and actionable conversation about bringing Louisiana's health care system into the 21st century. Thousands of people participated in the discussion at these community meetings and online, and many continue to stay engaged in the conversation through social media and direct communication with the Department. As a result of the CCN community forums across the state and countless meetings with provider and consumer groups, the Department was able to make additional enhancements to its original robust proposal to overhaul Louisiana's Medicaid program. The dialogue on Medicaid reform resulted in a stronger plan for Louisiana.

Challenges remain

While the state is working on systems and the building blocks of better health, DHH officials are acutely aware that the system is only part of the picture. The state continues to be limited by other health and social determinants that cannot be quickly addressed and will take sustained effort, involving more than government, to improve.

According to UHF's 2010 America's Health Rankings, 33.9 percent of Louisiana's population was obese, the fourth highest rate in the country and up from 28.9 percent just a year earlier. Too many Louisianians are also not engaging in the recommended level of physical activity. In 2007, 61 percent of Louisiana's adult population reported inadequate physical exercise, giving Louisiana the distinction of having the 2nd least active adult population in the country. One positive sign has been that while rates of smoking in Louisiana still remain higher than the national average (20.5 vs. 18.3 percent), these rates have steadily declined

for the past three years for which data is reported (more than 2 percentage points overall and more than 6 percentage points among 18-24 year olds in the last year alone).

These determinants of health translate into unnecessary chronic disease and deaths. The Behavioral Risk Factor Surveillance System revealed that 1 in 5 Louisiana residents reported being told they have a chronic health problem. According to UHF's 2010 America's Health Rankings, Louisiana also suffers from high rates of cancer deaths (220.1 per 100,000 people) and cardiovascular deaths (334.8 per 100,000 people). The Commonwealth Fund's 2009 State Scorecard ranked Louisiana 49th for the mortality rate amenable to health care with 137.2 deaths per 100,000, compared to a national average of 89.9.

Lack of access to preventive care, a fragmented Medicaid system, perverse financing mechanisms and high rates of unmanaged chronic disease, has led to high rates of avoidable hospital use and related costs. According to the Commonwealth Fund, Louisiana has the highest rates of avoidable hospitalizations among Medicare recipients and hospital admissions for home health patients. According to claims data, 44 percent of children with asthma in Medicaid visited the emergency room last year. More than 16,590 children in CommunityCARE (Louisiana's primary care case management program) had four or more ER visits in FY 2010. In FY 2009, Louisiana emergency rooms saw 546 visits per 1,000 in population, ranking it sixth in the nation and well above the national average of 415. This overreliance on in-patient and emergency room care is costly and diverts dollars away from less expensive and more effective primary care settings.

These statistics present a critical challenge to the state's health care leaders and policy makers who must have answers to our troubling questions: What is driving these outcomes? How is health care changing? And most importantly, what can we do to improve our health outcomes?

Business Review

General Overview

The mission of the Department of Health and Hospitals (DHH) is to protect and promote health and to ensure access to medical, preventive and rehabilitative services for all residents of the State of Louisiana. Our responsibilities include the provision of the state's safety net health insurance plan (Medicaid), as well as services for public health, behavioral health, aging populations and people with developmental disabilities.

In FY 2012, DHH has 8,458 authorized positions. These employees are divided among nine administrative regions and include staff at three state supports and services centers, one group home, three mental health hospitals, 68 parish health units, three specialty clinics, regional offices across the state, and public health offices in New Orleans and headquarters in Baton Rouge. Together, the DHH team manages the ongoing provision of hundreds of programs and initiatives through an annual budget that, in FY 2012, totals $8.25 billion.

Leadership and Management

The Office of the Secretary provides primary leadership and direction for the Department and is responsible for the coordination of statewide programs, services and operations. It establishes goals and objectives for the conduct of both routine and special departmental operations and provides technical support services. Appointed by the Governor, the Secretary serves as the executive head and chief administrative officer of DHH and has the overall responsibility for the policies of the department and for the administration, control and operation of the functions, programs and affairs of

the department. Bruce D. Greenstein is the current secretary of DHH, and has been in that position since September 2010. Reporting directly to the Secretary are the Deputy Secretary, Undersecretary and State Health Officer/DHH Medical Director.

The Deputy Secretary oversees the programmatic functions of the Department and directly supervises the offices of Public Health, Behavioral Health, Citizens with Developmental Disabilities and Aging and Adult Services. Kathy Kliebert is the current Deputy Secretary of DHH, and has been in that position since January 2011. The Undersecretary is essentially the Chief Financial Officer of DHH and oversees the state Medicaid program as well as several functions, including budget, financial planning, purchasing, human resources, accounting and contracts. Jerry Phillips is current Undersecretary of DHH, and has been in that position since February 2009. The Medical Director is responsible for medical consultation on a variety of health care policy issues, including health care programs and quality of care issues. The Medical Director also serves as the Department's liaison with medical, nursing, pharmacy, and allied health professionals as well as with professional associations and organizations throughout the state. The Medical Director's Office also houses the Office of Emergency Preparedness for DHH. The State Health Office is responsible for ensuring that the state sanitary code is enforced, a responsibility that he implements through the programmatic Offices of Public Health. Dr. Jimmy Guidry is the current State Health Officer of Louisiana, and has been in that position since January 2000.

Core Management Functions

Contracts and Procurement Support: The Division of Contracts and Procurement Support is responsible for all purchasing, contract and lease management, procurement, property management, telecommunications services, vehicle fleet services, mail operations and copier management for the Department.

Emergency Preparedness: DHH's emergency preparedness function, led by the DHH Medical Director, coordinates the response of public health and medical assets during a state-declared disaster such as a hurricane, chemical, biological, radiological, nuclear and explosive, mass casualty and mass fatality events. Emergency preparedness staff can mobilize instant communications systems with first responders and health care facilities to ensure response assets are utilized and deployed in an effective and timely manner.

Fiscal Management: Through financial management, payment management and support services, the Division of Financial Management directs a complex fiscal process for DHH to ensure that available financial resources are used properly and efficiently in accordance with state and federal rules, guidelines and laws.

Governor's Council on Physical Fitness and Sports: The mission of the Council is to encourage physical fitness and activity in the citizens of Louisiana by developing, fostering and coordinating relevant services. The Council fulfills this mission by providing information on physical fitness and sports through brochures, media events and fitness activities; serving as a clearinghouse for information relative to sports and physical education; conducting fitness seminars for senior groups; sponsoring physical fitness and sports workshops, clinics and conferences; and initiating a statewide awards program to recognize schools that have fitness-based physical education programs.

Health Economics: The Division of Health Economics provides policy support services to the Department's executive level managers and provides analytical, data management and research support to all offices of the Department. The Division plays a key role in designing and completing materials for presentation to legislative committees and works with Medicaid during the annual budget cycle to present a complete package of information and analysis for a broad audience. The Division has developed and maintains a collection of databases relating to program eligibility, health services utilization and Medicaid expenditure forecasting. The Division's staff works with all department offices to deepen the Department's database, information management and analytical resources.

Human Resources: The Division of Human Resources, Training and Staff Development

implements and monitors departmental human resource policies to ensure uniform employment and workplace practices regarding classification and wages, training and staff development, employment and promotions, employee relations and discipline, recruitment and benefits.

Information Technology: Primarily managing and administering hardware, software, and IT-related services, the Division of Information Technology assists its customers in the proper governance and business processes affecting all sectors of the state's population from a health care perspective.

Legal Services: The Bureau of Legal Services provides professional legal counsel, representation and services to the Department. The bureau's responsibilities include handling litigation, providing advice and counsel, overseeing administrative hearings, policy and contract review, recoupment, judicial commitments and interdictions, as well as handling civil service and personnel issues and ensuring compliance with health information privacy regulations and public records laws.

Legislative and Governmental Relations: The Legislative and Governmental Relations team serves as the primary liaison between the Department and members of the Legislature and other local and state elected officials. LGR provides health care information to elected officials and coordinates all legislative activities, which include reviewing and tracking all legislation that may impact health care or DHH, both as it moves through the process and during the implementation phase after passage.

Media and Communications: The Bureau of Media and Communications is responsible for obtaining, compiling, preparing and distributing department information to Louisiana residents, members of the news media and stakeholders across many different channels. The Bureau manages media relations, print publications, new media and the DHH website, as well as serves as a consultant to all program operations to ensure adequate, timely information is distributed to the public.

Minority Health Access: The Bureau of Minority Health Access works to improve the health status of medically underserved populations in Louisiana, including racial and ethnic minorities. The Bureau participates in state policy development, coordination of planning, programming, monitoring, and evaluation and coordination of minority health activities. The program uses multi-cultural approaches to enhance the design and delivery of health care services to minorities.

Planning and Budget: The Division of Planning and Budget directs and manages the budget process and coordinates operational planning, strategic planning and performance-based budgeting activities for the entire Department.

Office of Aging and Adult Services

The Office of Aging and Adult Services (OAAS) was created in 2006 and brings together all of the long-term care programs that serve senior citizens and people with adult-onset disabilities. OAAS also oversees the operation of Adult Protective Services and the Villa Feliciana Medical Complex. During the past year, the office successfully transitioned John J. Hainkel Jr. Home and Rehab Center to a non-profit private provider that has long been affiliated with its operation. OAAS administers nursing facility admissions, develops new long-term care programs and implements other health care reform recommendations. OAAS also administers home- and community-based long-term care services (HCBS) through Medicaid waiver (permission to operate outside of traditional program framework), state plan and state-funded programs for individuals who are elderly or have disabilities, helping them to remain in their homes and communities. The programs include the following:

Elderly and Disabled Adult Waiver: The Elderly and Disabled Adult (EDA) Waiver Program provides coverage for certain services in the home or community to seniors and adults with disabilities who qualify. This waiver will be replaced by the new, more comprehensive Community Choices Waiver in October 2011.

Adult Day Health Care Waiver: The Adult Day Health Care program provides health and social services to adults in a supportive and safe setting during part of a day.

Waiver Program:	Elderly & Disabled Adult Waiver	Adult Day Health Care Waiver
Number of people receiving services (filled slots)	4310	754
Total cost of program (SGF and total)	SGF: $25,839,763 **Total: $102,376,242**	SGF: $1,840,685 **Total: $7,292,731**

Long-Term Personal Care Services: The Long-Term Personal Care Services program provides coverage through the Medicaid state plan to help with activities of daily living such as bathing, dressing, transferring, toileting and eating for people who qualify for assistance under the program guidelines.

Program for All-Inclusive Care for the Elderly (PACE): This program coordinates and provides all needed preventive, primary, acute and long-term care services for the elderly to continue living in their communities while enhancing their quality of life.

Facility-Based Programs: Louisiana nursing facilities provide 24-hour care for rehabilitative, restorative and ongoing skilled-nursing care to patients or residents in need of assistance with activities of daily living. Individuals qualify medically for long-term care facility services if they meet the level of care criteria for admission to a nursing facility, have an order from a physician licensed in Louisiana for admission into a nursing facility, and are screened prior to admission for a history or active treatment of mental illness and/or developmental disabilities according to federal regulations.

Adult Protective Services (APS): APS is responsible for investigating and arranging for services to protect adults with disabilities, ages 18-59, who are at risk for abuse, neglect, exploitation or extortion. APS clients may include people who have developmental disabilities, mental illness or substance abuse problems, as well as those with medical problems or physical disabilities.

Traumatic Head and Spinal Cord Injury Trust Fund: OAAS administers the Traumatic Head and Spinal Cord Injury Trust Fund, in coordination with an advisory board. This program provides flexible, individualized services and assistance to Louisiana citizens who have suffered a traumatic head or spinal cord injury.

Office of Behavioral Health

Act 384 of the 2009 Legislative Session directed DHH to merge the Offices of Mental Health and Addictive Disorders into the newly created Office of Behavioral Health (OBH), which operates now on a total budget of about $340 million.

OBH oversees the state's three free-standing state psychiatric inpatient facilities: Central Louisiana State Hospital (CLSH), Eastern Louisiana Mental Health System (ELMHS) and Southeast Louisiana State Hospital (SELH). Collectively, they operate 708 hospital beds, including 330 adult forensic beds, 214 adult civil beds, 114 adult acute beds and 50 juvenile beds. In addition, the hospitals either directly or through contract operate 52 beds in community homes, an 82-bed residential Secure Forensic Facility and 133 less restrictive treatment beds.

OBH directly operates behavioral services in five regions of the state, with services in the additional regions administered by local governing entities (LGEs). Statewide, there are 77 outpatient clinics, 33 Access to Recovery (ATR) vendors, 392 direct service contracts and 62 community-based prevention providers.

OBH provides treatment and recovery support services for people suffering from mental illness and/or addictions to drugs, alcohol or gambling. Services include screening and assessment to ascertain the appropriate level and type of care needed. These levels of care include 24-hour inpatient and residential treatment, intensive and non-intensive outpatient care, community-

based recovery and support as well as crisis services. OBH also has regional prevention offices throughout the state that offer various services to decrease and prevent addictive disorders. Through strategic methods including school-based delivery, braiding resources, fee-for-service contracts and cost bands, with no increase in funding, the number of children receiving a substance abuse prevention program service expanded from 6,485 in FY 2006 to 77,171 in FY 2011, which is a 1,090 percent increase.

Inpatient & Residential Services

Detoxification Treatment: These services include social detoxification in a residential setting, medically supported detox in a non-hospital setting and medically managed detox in a hospital setting. Inpatient treatments provide secure hospital settings in which individuals can receive comprehensive and intense behavioral health services with a goal toward stabilization and return to the community. Levels of inpatient hospital care include acute and intermediate.

Forensic Hospitalization: This service provides a secure inpatient environment for those individuals the court has ordered into treatment as a result of having a behavioral health disorder and being charged with a crime. Individuals are provided behavioral health treatment up to the point at which the court determines they can be safely returned to court for trial or returned to the community.

Residential Treatment: This level of care provides services for those individuals who need addictive disorder treatment in a structured environment 24/7. There are four subcategories of intensity ranging from low-intensity residential treatment to medically-monitored intensive inpatient services. Halfway Houses/Three-Quarter Way Houses focus on re-socialization and encourage individuals to resume independent living and functioning in the community.

Facility-Based Outpatient Treatment Services

Outpatient & Intensive Outpatient Treatment: These services are provided for addictive disorders, mental illness and co-occurring disorders for children, adolescents and adults. Some specialized services offered in outpatient settings are medication management, specialized behavioral health counseling and therapy (such as multi-systemic therapy) and specialized group and individual therapies for co-occurring disorders.

Early Childhood Supports: This is a multi-agency preventive and intervention program that promotes a positive environment for learning, growth and relationship building for children. Crisis Response Services to address the needs of children and adults include Louisiana Spirit, Child Adolescent Response Team (CART) and clinic-based behavioral health crisis services available 24 hours per day, seven days per week.

Access to Recovery (ATR): This program provides clients with choice among substance abuse clinical treatment and recovery support providers. Recovery support services include alcohol and drug-free social activities, anger management, care coordination, childcare, family education, job readiness, life skills, pastoral counseling, recreational therapy, spiritual support, transitional housing and transportation.

Community-Based Services

Community-Based: These types of services provide treatment and support for individuals to function as independently as possible in the community. Interagency service coordination allows providers from multiple agencies to work together to provide a coordinated plan of care for children, adolescents and their families. School-based health centers (SBHCs) provide behavioral health services in school settings. Adult services include evidence-based programs such as Assertive Community Treatment (ACT), Intensive Case Management (ICM), Permanent Supportive Housing (PSH) and Forensic Aftercare Services (FAS) for those individuals the courts have permitted to be discharged from a forensic hospital.

Addictive Disorder Populations of Focus: OBH ensures that pregnant women and women with dependent children and injecting drug users are given preference in admission to treatment facilities. In addition, all clients with addictive disorders are screened for risk behaviors and

offered an HIV test. OBH also routinely makes tuberculosis services available to each individual receiving addiction treatment and monitors TB treatment service delivery.

Louisiana Behavioral Health Partnership (LBHP): In an effort to enhance service quality, facilitate access to care and effectively manage costs, the Department is restructuring the current service delivery mechanisms by developing and implementing a comprehensive system for behavioral health services. LBHP will serve an estimated 150,000 adults and children with serious mental illness, emotional disorders or addictive disorders. A component of this initiative, the Coordinated System of Care (CSoC), will address the special needs of children in or at-risk of out-of-home placement. This intensive wraparound service delivery model is being developed in conjunction with the Department of Children and Family Services, the Department of Education and the Office of Juvenile Justice. More information about these initiatives is found within the transformational priorities section of this document.

Office for Citizens with Developmental Disabilities

The Office for Citizens with Developmental Disabilities (OCDD) is committed to ensuring quality services, supports, information and opportunities for choice to Louisianians with developmental disabilities and their families. OCDD oversees public and private residential services and community-based services for children and adults with developmental disabilities. OCDD serves as the single point of entry into the developmental disabilities service system and provides community-based services through its regional offices or local governing entities. OCDD also directly supervises the administration of the state's three supports and services centers and one group home.

Through four home- and community-based waiver programs, OCDD, in partnership with Louisiana Medicaid, is able to offer individuals greater flexibility to choose where they live and use services and supports that best meet their needs.

Children's Choice Waiver: This waiver offers supplemental support for children through age 18 who live at home, with their families or with a foster family.

New Opportunities Waiver (NOW): This waiver offers people age 3 years old and older, who otherwise require an institutional level of care, services that provide them the opportunity to remain in their communities.

Supports Waiver: This waiver offers focused individualized vocational and employment services for people 18 years old and older.

Residential Options Waiver: This waiver offers people of all ages services designed to support them to move from institutional care to community-based settings.

Waiver Program:	Children's Choice	New Opportunities Waiver	Supports Waiver	Residential Options Waiver
Number of people receiving services (filled slots)	980	7491	1718	25
Total cost of program (SGF and total)	SGF: $2,147,749	SGF: $76,957,629	SGF: $2,584,516 SGF	SGF: $219,138 SGF
	Total: $10,525,600	**Total: $377,150,841**	**Total: $12,666,093**	**Total: $1,073,943**

OCDD also administers several other programs aimed at supporting individuals with developmental disabilities living within the community.

EarlySteps: This program provides services to families with infants and toddlers up to 3 years old who have a medical condition likely to result in a developmental delay or who have developmental delays. EarlySteps services are designed to improve the family's capacity to enhance their child's development and are provided in the child's home, child care environment or any other community setting typical for this age group.

Cash Subsidy: This program assists children with the most severe disabilities to stay in the home with their families. Cash Subsidy program funds cover extraordinary costs associated with raising a child with a disability.

Individual and Family Support: Flexible funding is made available through a prioritization process based on individual level of need and risk of health and safety or out-of-home placement. These funds allow children and adults with developmental disabilities to live in their own homes or with their families in their home community.

Community Support Services: Community supports and services are provided for people who need intensive treatment intervention, such as psychological services, nutrition counseling and family counseling to live successfully in the community.

Resource Centers: OCDD Resource Centers are designed to build the capacity of community providers. Services provided include training opportunities, training curriculum development, provision of resource materials, resource guides, peer reviews and program reviews.

Supports and Services Centers: The DHH-operated supports and services centers provide a residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health and rehabilitative needs. OCDD operates one group home and three supports & services centers (formerly called developmental centers).

- Leesville Residential and Employment Services Center (group home)
- Northlake Supports and Services Center
- Northwest Supports and Services Center
- Pinecrest Supports and Services Center
- Center for Health Care Innovation and Technology

Center of Health Care Innovation and Technology

The Center of Health Care Innovation and Technology (CHCIT) researches, develops and assists with implementation of new initiatives within the Department. This team is responsible for the coordination and development of legislative reports, policy papers and other public documents issued by the Department. CHCIT is responsible for monitoring and coordinating the Department's efforts related to the Affordable Care Act (ACA) and other changes in federal law.

CHCIT also monitors federal law and policy, monitors major health system changes across the state and country and works with each DHH office to ensure the maximization of resources and effective systems to collect and analyze data. CHCIT also houses the position of Health Information Technology Coordinator, who monitors and directs the work being done through a series of grants intended to enhance the use of information technology in Louisiana's health care community. CHCIT has four primary functions: policy, health information technology, technology integration and analytics.

Louisiana Medicaid

Medicaid is the state's health coverage program for low-income residents who meet certain eligibility qualifications. Administered through DHH's Bureau of Health Services Financing, Medicaid is funded in partnership between the federal and state government. Medicaid has an FY 2012 budget of just more than $7 billion, of which just more than $2 billion is state funds. The program provides medical benefits such as physician, hospital, laboratory, x-ray, long-term care and nursing home services to approximately 1.2 million eligible residents, the majority being children under age 19.

In addition to traditional Medicaid, the Medicaid program offers different types of coverage for different eligibility categories. Some of these include:

Louisiana Children's Health Insurance Program (LaCHIP) offers health insurance to children from

working families where parents earn up to 200 percent of the federal poverty level (about $3,675 monthly for a family of four).

LaCHIP Affordable Plan covers children whose parents earn too much to qualify for LaCHIP, but earn below 250 percent of federal poverty level.

Medicaid Purchase Plan helps people with disabilities keep Medicaid benefits they qualify for while they work.

Louisiana Health Insurance Premium Payment (LaHIPP) program may pay all or part of the health insurance premiums for insurance available through your job if that is more cost effective than letting you or your relative remain on Medicaid.

Family Opportunity Act Medicaid lets higher-income families who have children with disabilities buy into the Medicaid program for health care coverage.

LaMOMS offers no-cost health coverage to pregnant women for all prenatal and delivery care.

TAKE CHARGE offers no-cost health coverage to Louisiana women ages 19-44 who don't have health insurance, earn below 200 percent of federal poverty level and need access to family planning services.

Breast and Cervical Cancer Program, operated through the LSU Health Sciences Center Women's Preventive Health Program, provides no-cost health coverage for treatment of breast and cervical cancer.

Long-Term Care Services offers qualified individuals either in a facility or in their homes.

Medicare Savings Program will pay Medicare premiums and related expenses for senior citizens who meet certain qualifications.

Seniors Health Insurance Program (SHIP), run by the Louisiana Department of Insurance through a grant from the Health Care Financing Administration, offers health insurance counseling and information to senior citizens.

Medicaid is currently operated under a traditional fee-for-service payment structure, with more than 750,000 of its enrollees receiving modest care management through the state's primary care case management (PCCM) program called CommunityCARE. CommunityCARE will end in 2012 as a new approach to service delivery -- Coordinated Care Networks (CCNs) -- are phased in across the state to provide comprehensive care management to enrollees. See more about the CCN program in the Transformational Priorities section.

Office of Public Health

The Office of Public Health (OPH) protects and promotes the general health of Louisiana residents and is centered on population-based health concerns. This includes implementation and enforcement of the sanitary code, provisions of personal and environmental health services in parish health units, sewerage treatment and disposal, supplemental food programs, emergency preparedness and other functions affecting the public's health. OPH also monitors the aspects of environmental quality and pollution control that apply to public health and which are specifically assigned to DHH.

OPH oversees more than 50 programs and initiatives through six centers: records and statistics, environmental health, community and preventive health, community preparedness, primary care and rural health and emergency medical services.

Vital Records and Statistics: This center oversees operations related to the maintenance, certification, sale and preservation of birth, death, marriage and other vital records. Vital Records is implementing the Louisiana Electronic Event Registration System (LEERS), a web-based vital records registration system that includes the birth, death, fetal death, marriage, divorce and induced termination of pregnancy modules, which are integrated with a state-of-the-art business module and an imaging system for scanning and saving approximately 10 million archived records.

Center for Environmental Health: This center is responsible for the implementation, promulgation and enforcement of the Louisiana State Sanitary Code; promoting the control and/or reduction of acute and chronic diseases caused by unsafe environmental conditions; developing and enforcing environmental protection regulations; investigating health hazards; providing leadership in programs that allow for the prevention and control of disease; and setting standards for excellence by

being customer-focused, responsive, accessible and efficient. Through the employ of 206 state sanitarians, OPH conducts inspections of facilities including retail food establishments, community water, private sewerage and water systems, food manufacturers, tanning facilities, milk and milk product processing facilities, commercial seafood processors, and institutions such as schools, daycares, nursing homes, hospitals, and places of incarceration. State sanitarians also monitor eight million acres of Louisiana oyster growing waters, including oyster sampling and testing.

Center for Community Health: This center provides services which aim to minimize the occurrence of disease and its consequences. The Center provides nursing and pharmacy services through a system of regional offices and parish health units, preventive health services and screening, and ensures optimum pre-hospital emergency medical services. This includes reducing exposure to health threats, detecting and treating diseases in early stages, and alleviating the effects of disease and injury. This is done through a variety of programs, including children's special health services; hearing, speech and vision; family planning; genetic diseases; maternal and child health; nutrition services; immunizations; sexually transmitted disease control, including HIV/AIDS; and tuberculosis control.

Center for Community Preparedness (CCP): CCP uses an all-hazards approach to integrate state and local public health jurisdictions for response to public health threats. The Center is organized according to the National Incident Management System, Incident Command Structure (ICS). Components of ICS include command, administration & finance, logistics, operations and planning. This structure allows for efficient management by integrating processes, personnel, communications and equipment on a day-to-day basis, as well as during emergencies. Programs under the Center include: emergency preparedness & response, pandemic flu, training and exercises, strategic national stockpile (SNS), cities readiness initiative, CHEMPACK, health alert network (HAN), volunteer management, community outreach, emergency medical social services, and workforce development.

Bureau of Primary Care and Rural Health (BPCRH): BPCRH provides technical assistance to communities, federally qualified health centers, physician practices, rural health clinics and small rural hospitals. Additionally, the Bureau works to support effective clinical practices and health care organizations. The Bureau currently provides services through six units: Health Systems Development, Recruitment and Retention Services, Practice Management Consulting, Health Information Services, the Statewide Pharmacy Access Initiative and Chronic Disease Prevention and Control. Together, staff members work across units to provide a continuum of services to establish, enhance and sustain health care services for all Louisiana residents.

Bureau of Emergency Medical Services: This office is responsible for the improvement and regulation of emergency medical services in Louisiana. They are mandated to promulgate and enforce rules, regulations and minimum standards for course approval, instruction, examination and certification. They are also responsible for developing a state plan for the prompt and efficient delivery of emergency medical services through education, examination, and certification of all EMS personnel in Louisiana.

Human Services Districts and Authorities

Authorized by the Louisiana Legislature, human services districts are locally governed public agencies committed to enhancing the quality of life of individuals faced with the challenges of mental health, addictive disorders, developmental disabilities and their related behaviors. In the regions they serve, they replace the services normally offered by DHH regional offices of Behavioral Health and Citizens with Developmental Disabilities. The Districts offer comprehensive systems of care which provide research-based prevention, early intervention, treatment and recovery support services. The Districts combine relevant resources to foster community collaboration resulting in a dynamic and comprehensive system of service delivery.

There are currently five human services districts serving different areas of the state.

- Metropolitan Human Services District (Orleans Parish)

- Jefferson Parish Human Services Authority
- Capital Area Human Services District
- Florida Parish Human Services Authority
- South-Central Louisiana Human Services Authority

TRANSFORMATIONAL PRIORITIES

These 20 transformational priorities are grouped under three common themes:

- Building Foundational Change for Better Health Outcomes
- Promoting Independence through Community-Based Care
- Managing Smarter for Better Performance

Building Foundational Change for Better Health Outcomes

Medicaid Coordinated Care Networks (CCNs)

Background

According to a U.S. Government Spending Report, Louisiana spent $7.4 billion in 2010 on health care.[1] Louisiana's Medicaid program currently provides coverage for approximately 25 percent of its population, [2] reimburses for approximately 70 percent of the state's births annually, and accounts for approximately 30 percent of the health care dollars spent in Louisiana. It has a huge impact on our health outcomes, but our state misses a critical opportunity to make a significant positive impact. Today, Louisiana has a fragmented Medicaid service delivery system that operates almost exclusively in a fee-for-service system environment that has little to no coordination, uneven quality of care, inequitable access to care and unpredictable costs. Put plainly, patients see their health care providers, providers bill the state and Louisiana simply pays the bill, all the while doing little to coordinate care. Our health care system was designed to provide episodic and acute care for heart attacks, pneumonia, appendicitis, stroke, flu, accidents and other conditions where people break, then mend.[3]

The system was not designed to promote and maintain health. According to the United Health Foundation's 2010 America's Health Rankings, Louisiana ranks 49th in the nation based on 22 health determinants and health outcomes measures.[4] According to Annie E. Casey Foundation's 2010 KIDS COUNT Data Book, Louisiana ranks 49th in the nation based on 10 measures that profile the well-being of children.[5]

Louisiana's challenge is twofold: designing and implementing a system of care that will be able to improve its health outcomes and moving our state from the bottom in health rankings, while doing so in the context of continued budget deficits and efforts to streamline government.

Based on extensive research and stakeholder input, DHH is transitioning Louisiana's Medicaid program to a managed care delivery system through the development of Coordinated Care Networks (CCNs). DHH has carefully studied the experiences of other states, identifying best practices and practices to be avoided, and has consulted with experts and stakeholders across the state and the country. The Department has used those "lessons learned" to develop two models of coordinated care that represent the best evidenced practices for improving health outcomes, increasing access to quality care and providing fiscal sustainability. A large body of evidence exists regarding the benefits of the Medicaid coordinated care model. The Lewin Group's report, *Medicaid Managed Care Cost Savings—A Synthesis of 24 Studies* concludes that Medicaid

managed care programs can yield savings while improving access to and continuity of care.

Goal

The overall goal of the CCN program is to improve health care service delivery that results in better health outcomes for Medicaid and LaCHIP enrollees. The official Request for Proposals for CCNs, issued April 11, 2011, contained the following specific goals:

- Improve coordination of care;
- Establish a patient-centered medical home for Medicaid recipients;
- Improve health outcomes;
- Increase quality of care as measured by metrics such as HEDIS;
- Emphasize disease prevention and management of chronic conditions;
- Diagnose earlier and treat acute and chronic illness;
- Improve access to essential specialty services;
- Promote healthy behaviors;
- Increase personal responsibility and self-management;
- Reduce the rate of avoidable hospital stays and readmissions;
- Decrease fraud, abuse and wasteful spending;
- Provide greater accountability for the dollars spent;
- Yield a more financially sustainable system; and
- Create a net savings to the state compared to the existing fee-for-service Medicaid delivery system.

Program Strategy & Operations

Louisiana's transition to CCNs includes two coordinated care models. Both models will provide a patient-centered medical home and a greater array of care coordination functions, including utilization management, care management, quality, management of chronic illness, meaningful use of electronic health records and accountability through the reporting of performance measures. The two models are:

Coordinated Care Network – Shared Savings (CCN-S) is an enhanced primary care case management (ePCCM) program. The CCN-S enrollees are linked to a primary care case manager, who will receive $13.31 or $19.66 monthly as a management fee for each member based on the risk category of the enrollee. The CCN-S primary care providers serve as the "medical home" for primary care and provide coordination of medically necessary services. The CCN-S must meet performance outcomes to receive any shared savings.

Coordinated Care Network – Prepaid (CCN-P) is a comprehensive full risk prepaid Medicaid managed care program. CCN-P plans are paid a per-member-per-month (PMPM) capitated rate and are responsible for providing and/or arranging for all or a majority of Medicaid-covered services for their enrollees. Plans accepting full risk will increase Medicaid budget predictability and improve access to specialty care. CCN-P plans will be able to negotiate rates with specialists. The CCN-P must meet strict network adequacy requirements and performance outcomes or be subject to financial disincentives.

Both CCN models will incorporate outreach and education to promote healthy behaviors, including seeking and participating in appropriate health care that incorporates early screening and detection, increased personal responsibility and self-management. Each of the following elements of better health is integral to the CCN design.

- Disease Management – A strong focus on intensive case management and improved coordination of care for high cost individuals.
- Preventive Services – Recognition that preventive services will detect medical problems before they occur or before they become acute.
- Primary Care and Emergency Services – It is projected that with increased primary care access, there will be a corresponding decrease in emergency department care.

- Payment Reform – Recognizing and reimbursing for the value of services for which Medicaid does not currently reimburse. Payment structure and incentives will reward adherence to evidence-based care that increases quality and reduces unnecessary medical treatments (e.g., adoption and use of electronic health records).
- Quality Providers – Metrics and standards will be used to evaluate participating providers and Medicaid will provide resources and tools to help them improve their services, thereby improving health care outcomes.
- Health Disparities – Focusing on preventive services for all Medicaid and LaCHIP enrollees and targeting diseases and areas with the most acute health problems can begin to reduce the racial and geographic disparities in health care access and quality.

The new CCNs will provide coordination of care; greater accountability for the dollars spent; greater health promotion and disease prevention; and increased access to essential specialty services and diagnosis and treatment of acute and chronic illnesses.

Select Performance Objectives and Measures for FY 2012:

To encourage member choice and responsibility (CCN-S and CCN-P),

- 70 percent or more of new eligibles will proactively choose their own CCN.

To ensure timely access to appropriate services (CCN-S and CCN-P),

- 95 percent of calls to primary care physicians (PCPs) during and after regular business hours are returned within 30 minutes of the call (24 hours per day, 7 days per week);
- 80 percent of standard service authorization determinations are made within two business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure or service requiring a review determination. 100 percent are made no later than 14 calendar days following receipt of the request for service unless an extension is approved by DHH; and
- 100 percent of expedited service authorization determinations are made no later than 72 hours after receipt of the request for service.

To ensure timely claims processing and payment,

- 99 percent of claims are pre-processed by the CCN and submitted to the fiscal intermediary within 24 hours of receipt from provider (CCN-S); and
- 90 percent of all clean claims of each provider type are paid within 15 business days of the date of receipt and 99 percent are paid within 30 calendar days of the date of receipt (CCN-P).

To encourage appropriate resolution of member grievances at the CCN level (CCN-S and CCN-P),

- 10 percent or less of grievance decisions appealed to the state fair hearing level period are overturned.

Louisiana's actuary, Mercer, projects savings for core benefit and services provided through the CCNs will be $24 million for FY 2012 and $135 million for FY 2013.

DELIVERABLES

- Host advocate summit *October 2011*
- All CCN contracts to CMS for approval *October 2011*
- Launch education and outreach campaign *November 2011*
- GSA A (phase 1) provider networks submitted to CMS for approval *November 2011*
- GSA A choice letters mailed and enrollment in CCNs begins *December 2011*
- GSA B (phase 2) contracts and provider networks submitted to CMS for approval *January 2012*
- GSA A "Go Live" for CCN core benefits and services *February 2012*
- GSA B choice letters mailed and enrollment in CCNs begins *February 2012*
- Complete execution of provider agreements with CCNs in all areas of the state *March 2012*
- GSA C (phase 3) contracts and provider networks submitted to CMS for approval *March 2012*
- GSA B "Go Live" for CCN core benefits and services *April 2012*

- GSA C choice letters mailed and enrollment in CCNs begins *April 2012*
- GSA C "Go Live" for CCN core benefits and services *June 2012*

1 U.S. Government Spending, http://usgovernmentspending.com/spend.php?span=usgs302&year=2010&view=1&expand=10&expandC=&units=b&fy=FY2012&local=s&state=LA&pie=#usgs302.

2 Medicaid Enrollment as a Percent of Total Population, 2007, Kaiser Family Foundation, Statehealthfacts.org, http://www.statehealthfacts.org/profileind.jsp?cmprgn=20&cat=4&rgn=38&ind=199&sub=52

3 A New Blueprint for Health Care Reform (an Executive Summary), Louisiana Business Group on Health, June, 2006.

4 America's Health Rankings: Louisiana, 2010. United Health Foundation. http://www.americashealthrankings.org/yearcompare/2009/2010/LA.aspx

5 KidCount Data Center: Louisiana. Annie E. Casey Foundation, 2010. http://datacenter.kidscount.org/data/bystate/StateLanding.aspx?state=LA

6 Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies, Prepared for America's Health Insurance Plans, The Lewin Group, July 2004, Updated March 2009.

Louisiana's Vision for Health Information Technology

Background

The Department of Health and Hospitals is working closely with partners and stakeholders statewide to execute Louisiana's vision for Health Information Technology (HIT). The use of technology to improve care is one of the four core business objectives of the Department, and HIT makes it possible for health care providers to better manage patient care through secure use and sharing of health information. This initiative includes four separate projects that collectively make up the foundation of Louisiana's HIT agenda.

- Louisiana Medicaid Electronic Health Record (EHR) Incentive Program
- Crescent City Beacon Community (CCBC)
- Louisiana Health Information Exchange (LaHIE)
- Louisiana Health Information Technology (LHIT) Resource Center

Through the implementation of these programs, Louisiana seeks to positively impact the quality, safety and efficiency of health care. By incenting and assisting in the adoption of EHR systems and creating a network of health information sharing, providers should gain efficiency through productivity and a reduction in the burdens of documentation of duplicative procedures and/or tests. This will yield improved quality of care by enabling better clinical decision support at the point of care and giving providers the ability to access the right information for the right patient at the right time. Ultimately, this will lead to safer environments for care by reducing cases of misdiagnosis or, at times, fatal drug-to-drug interactions and allergic reactions.

Louisiana Medicaid EHR Incentive Program:
The Medicaid EHR Incentive Program provides incentive payments to eligible professionals, eligible hospitals and critical access hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology in their first year of participation. They will receive additional payments for demonstrating meaningful use for up to five remaining participation years. Eligible professionals can receive up to $63,750 over the six years they to participate in the program.

Louisiana began its Medicaid EHR Incentive Program in March 2010, and on January 7, 2011 became the first state in the country to process an incentive payment to a Federally Qualified Health Center and the third state to pay a Medicaid EHR Incentive payment. As of August 19, 2011, Louisiana Medicaid had paid more than $40.2 million to eligible providers and hospitals across the state, making Louisiana a national leader in incentive payments.

Crescent City Beacon Community (CCBC):
The Crescent City Beacon Community program originated as a $13.5 million grant awarded to the Louisiana Public Health Institute (LPHI) by the federal Office of the National Coordinator (ONC). CCBC is one of 17 beacon communities across the U.S. with an emphasis on population health improvement through clinical transformation and quality improvement with technology as the key enabler. The program provides funding for the selected communities to build and strengthen their HIT infrastructure and exchange capabilities. It also supports these communities at the cutting edge of EHR adoption and HIE to push them to a new level of sustainable health care quality and efficiency.

The program will also demonstrate how other communities can use HIT to achieve similar goals.

LPHI initially served as the lead applicant in the Beacon proposal to ONC and now serves as the aggregate Project Management, Assurance & Fiduciary Agent on behalf of the CCBC. The current members of this growing collaborative include Interim LSU Public Hospital; Ochsner Health System; Community-based health centers; Tulane Medical Center; Metro New Orleans' School-Based health centers; Louisiana Public Health Institute; Children's Hospital and Touro Infirmary.

CCBC's partner-approved interventions are in diabetes and cardiovascular disease. The Beacon hopes to improve quality of care for chronic patients in patient-centered medical homes to impact population outcomes for chronic disease. It will accomplish this goal by implementing mutually agreed upon standards of care in EHR and clinic workflow and a care management model. The Beacon also hopes to reduce health care costs by decreasing preventable emergency department and in-patient visits through better coordination of care.

Louisiana Health Information Exchange (LaHIE): Last year, the federal Office of the National Coordinator (ONC) within the United States Department of Health and Human Services (HHS) announced State Health Information (State HIE) Exchange Cooperative Agreement Program awards to 56 states, eligible territories and qualified state designated entities. Louisiana was awarded $10.6 million through its state designated entity, the Louisiana Health Care Quality Forum (LHCQF). The program funds Louisiana's efforts to rapidly build capacity for exchanging health information across the health care system. The LHCQF seeks to employ HIT to enable improvements in health, minimize variations in care and address disparities in health care delivery.

The Louisiana Health Information Exchange (LaHIE) will leverage existing HIE capacity among providers that have functional and certified EHRs in place and that are ready to engage in sharing of health information. LaHIE will monitor and evaluate meaningful use criteria for its impact on HIE and ensure services are provided based on those criteria. LaHIE envisions providing support for providers in the following areas: electronic prescribing; electronic lab ordering and deliver; quality reporting; electronic eligibility determination; patient access to health information; exchanging clinical information including summary care records for transitions in care; providing reporting capabilities to DHH's Office of Public Health (OPH); and maintaining required levels of privacy and security.

LHCQF has selected Orion Health to be Louisiana's HIE Vendor. Currently, efforts are being made to adopt a business plan and an execution plan for Phase I "go-live," which will take place in early November. Phase I includes base HIE functionality such as demographics, encounters, allergies, laboratory results, radiology and transcribed document sharing. Additionally, Phase I will address the master patient index, consent management, transaction logging, audit trail, provider directory and a clinical/HIE portal among many other areas.

Louisiana Health Information Technology Resource Center (HITRC): The National Health Information Technology Extension Program consists of Health Information Technology Regional Extension Centers (RECs) and a national Health Information Technology Resource Center (HITRC). RECs are intended to support and serve health care providers to help them quickly become meaningful EHR users.

In April 2010, the LHCQF, as the state designated entity, was awarded $6.2 million to establish the REC Program in Louisiana. The Louisiana HITRC is charged with ensuring primary care clinicians get the help they need to use EHRs with the goal of providing outreach and support services to 1,042 priority primary care providers to achieve meaningful use by April 1, 2014. In September 2010, an additional $768,000 was awarded to expand that goal to include 64 critical access and rural hospitals in their efforts to adopt certified EHR technology. Two additional awards were announced in February 2011. LHCQF was awarded an additional $384,000 for critical access and rural hospitals and another $408,973 in REC funding for eligible professionals.

Goal

Collectively, the goal of these initiatives is the successful adoption and use of HIT to deliver higher quality, more efficient health care and produce better outcomes for Louisiana residents. DHH will work to not only quantitatively measure the HIT adoption in the state, but to define and measure the qualitative impact of adoption through the impact to health care costs and improvements in health outcomes.

Program Strategy and Operations

DHH plays a different role in each of the following HIT initiatives. DHH is solely responsible for the execution of the Medicaid EHR Incentive Program and will work through FY 2012 to increase efficiency through the introduction of an automated payment process; an improved communication strategy and enrollment process; and the continued tracking and reporting of progress to federal, state and local partners through dashboards.

For the LaHIE and LHIT projects, DHH will support the LHCQF and continue to monitor the progress of these initiatives to ensure that deliverables are met in a timely manner. Likewise, DHH will assist LPHI and its partners to ensure successful implementation of the goals of the CCBC. While DHH is only one partner in this effort, we will play a leadership role in ensuring collaboration across the stakeholder community.

Louisiana Medicaid EHR Incentive Program

The EHR team is working with the systems contractor and Medicaid staff to ensure rapid, but accurate, payment to entities applying for incentive payments. By taking advantage of enhanced federal funding, DHH will be able to devote more staff and resources to program operations, program integrity and provider relations. Additionally, the automation of the payment processing system will reduce human errors frequent in manual processing and decrease the time from application submission to payment issuance. Since high rates of EHR adoption are crucial to the success of HIEs, the EHR team will work closely with the LHCQF and its REC program to provide outreach and education to eligible professionals and hospitals throughout the state.

The EHR Incentive Program will increase participation in the program by 200 percent by the end of FY 2012. Central to achieving the goals set forth in the HITECH Act is the realization of meaningful use objectives. Therefore, the program will work to ensure that at least 75 percent of those providers who received adopt/implement/upgrade (AIU) payments in year one will be ready to attest to stage 1 meaningful use by June 2012. The EHR Incentives Team will also be heavily engaged with the provider community in soliciting feedback on how to improve the program. The team will also collect data to be used to measure the effectiveness of the program in achieving its goals of reducing medical errors, providing easy access to patient information, engaging patients in their health care and providing alerts and reminders that improve patient safety.

Crescent City Beacon Community (CCBC)

DHH executive leadership will closely monitor and assist the LPHI as necessary to help them meet the program goals. DHH leadership will coordinate across the Department, other ARRA HITECH grantees and other state stakeholders to ensure that program objectives are being met and that they align with the Department's business strategies. The DHH Secretary will continue to serve in his role on the steering committee of the Beacon Project. The steering committee is responsible for ensuring project success, strategic visioning, oversight and direction of the CCBC Operating Board, approval of project critical path milestones and deliverables, stakeholder alignment, political engagement and the communication of CCBC goals to the broader community.

LPHI will also work with the Louisiana Health Information Technology Resource Centers in aligning quality measures and integrating community accountability. Integration with the IT infrastructure provided by the LaHIE is also planned along with alignment of analytics. LPHI will share its lessons learned on the value proposition provided by HIEs and practice transformation to the LHCQF as well.

Louisiana Health Information Exchange (LaHIE) and Louisiana Health Information Technology Resource Center (HITRC)

DHH executive leadership will closely monitor and assist the LHCQF to help assure successful implementation of LaHIE, HITRC and expansion of statewide health information exchange. DHH will foster relationships with public and private partners/stakeholders to ensure coordination of electronic information systems planning, development, implementation and exchange of information. As the state agency primarily responsible for HIT/HIE execution, DHH will coordinate related activities across all state and federal agencies, including Medicaid and public health, as well as coordination with other ARRA-funded programs in Louisiana. Furthermore, DHH will work to identify improvements in the management, availability and use of public health and health care data to assess and improve the health status of Louisiana residents.

LaHIE plans for implementation to be complete by November 2011. Current projections are for at least 15 of the state's 138 acute care hospitals to "go live" by the end of FY 2012. As the large hospitals "go live" on the HIE, they will bring all of their affiliated physicians with them, greatly increasing the number of exchange users. The LHCQF plans to incent early adoption of the HIE by waiving subscription fees for the first year if the provider goes live within six months of signing up.

The LHCQF has also identified 11 integration services that LaHIE will facilitate in the future. These services comprise a key value-add for the business model and allow hospitals and physicians to realize savings through integration. The DHH services LaHIE is targeting for integration are Louisiana Immunization for Kids Statewide (LINKS), Electronic Medicaid Eligibility Verification System (eMEVS), syndromic surveillance, infectious diseases, eLab reporting, birth outcomes, analytics, LEERS/vital statistics, EMSTAT, an emergency management status reporting system, and other program registries. LHCQF and the HIT Coordinator will work to ensure that four of these services are in place and facilitated by LaHIE during FY 2012.

LHIT will shift its focus from enrollment to other milestones during FY 2012. It will provide the technical assistance needed to its enrollees so that 20 percent of them will meet meaningful use stage 1 by June 2012. Furthermore, at least 40 percent of its enrolled providers and hospitals will be in "go live" status by the end of FY 2012.

DELIVERABLES

Louisiana Medicaid EHR Incentive Program

- Finalize revised eligible hospitals worksheet and receive approval from CMS to resume issuing payments *July 2011, Aug 2011*
- EHR team will collaborate with Medicaid Program Integrity to develop and implement an audit plan in accordance with federal regulation to be included in next State Medicaid HIT Plan (SMHP) update *July 2011- Sept 2011*
- EHR staff will draft HIT I-APD update to be sent to CMS for year 2 funding of the program's administrative costs *Sept 2011*
- EHR staff will address CMS concerns and questions in its final HIT IAPD to be sent to CMS for approval by 10/5/2011 *Sept 2011, Oct 2011*
- Implementation of web-based registry and attestation system *Nov 2011*
- EHR Program staff and Molina will collaboratively develop provider manuals and communication materials for eligible hospitals and providers. Molina will develop an online user manual *Oct 2011-Dec 2011*
- Submit revised SMHP to CMS for approval *Nov 2011*

Crescent City Beacon Community (CCBC), ONC HITECH Beacon Community Program

- Update DHH and HIT dashboards monthly to include Beacon metrics *July 2011-June 2012*
- Review and provide regular feedback to the CCBC's policy strategy to ensure that all program resources are leveraged toward the program's success *July 2011-June 2012*

Louisiana Health Information Exchange (LaHIE), ONE HITECH State HIE Cooperative Endeavor Agreement

- Update DHH and HIT dashboards monthly to include HIE program metrics *July 2011- June 2012*
- Review and provide regular feedback to LHCQF's policy strategy to ensure that all program resources are leveraged toward the

success of the program with regard to the HIE in the following specific areas: patient privacy and security, regulatory, provider participation/ incentives, payment reform, governance and sustainability, others as needed *Sept 2011, Dec 2011, Mar 2012, June 2012*

- Organize Pilot LaHIE Launch *Oct 2011*
- Review and assist with efforts to mainstream launch of LaHIE *Jan 2012*
- Adjust DHH IT infrastructure to ensure HIE interface with LaHIE for DHH programs (Immunization, Electronic Lab Reporting, Public Health Surveillance) *July 2011- June 2012*

LHIT Resource Center, ONE HITECH REC Program

- Review and provide regular feedback to LHCQF's policy strategy to ensure all program resources are leveraged toward the success of the REC program *July 2011-June 2012*
- Align the Medicaid EHR Incentive Program with the REC program messaging and ensure that appropriate resources are available to address questions and requests from the REC staff *July 2011-June 2012*
- Update DHH and HIT dashboards monthly to include REC program metrics *July 2011-June 2012*

Greater New Orleans Community Health Connection (GNOCHC Clinics)

Background

The Greater New Orleans area, comprised of Orleans, Jefferson, St. Bernard and Plaquemines parishes, is one of the largest population centers in the state. According to the 2010 Census, it is home to 835,290 individuals and represents 18 percent of the state's population. But, according to the 2009 American Community Survey, 39 percent of individuals living in the New Orleans area had incomes below 200 percent of the federal poverty level and 19 percent were uninsured, making the area one of the most vulnerable in the nation. This survey also indicates that low-income adults are more likely than other adult residents to have a health problem. Overall, nearly two-thirds of residents reported a chronic illness, 37 percent reported hypertension or high blood pressure, 17 percent asthma or other breathing problems, 15 percent serious mental illness, 15 percent diabetes or high blood sugar, and 11 percent heart disease. Thirty-one percent of the residents reported general mental health challenges.

Prior to Hurricane Katrina, much of the health care for the low-income and uninsured population in the Greater New Orleans area was provided in emergency departments and outpatient clinics at LSU's Charity and University hospitals. In the aftermath of Hurricanes Katrina and Rita, DHH was awarded a $100 million Primary Care Access and Stabilization Grant (PCASG) program to restore and expand access to primary care services, including mental health care services and dental care services, without regard to a patient's ability to pay.

During the grant period, PCASG clinics served more than 292,000 individuals with approximately 1.3 million visits, nearly 20 percent of the region's population annually. Of those served, 43 percent were uninsured and an estimated 60,000 of those had incomes below 200 percent of the federal poverty level. Under difficult conditions, the network developed into a successful new model for rapidly building capacity for quality primary care and community mental health services. The PCASG clinics became an important source of care for a largely disadvantaged population that historically relied on the public hospital and emergency rooms for primary care.

The PCASG grant ended in September 2010, and DHH has worked with local and federal officials to preserve the access to primary and behavioral care built by the original 25 organizations (87 clinics) that participated in the grant. To do so, DHH committed $32.5 million in Community Development Block Grant (CDBG) funds and secured approval from the Centers for Medicare and Medicaid Services (CMS) for a Medicaid demonstration waiver, effective October 1, 2010 through December 31, 2013, that will use $97.5 million of Disproportionate Share Hospital (DSH) funding to support a patient-centered medical home model serving the uninsured, low-income adult population to be covered through the Medicaid expansion and State Health Benefits Exchange mandated by the Affordable Care Act effective beginning in 2014.

Goals

- Preserve most of the primary and behavioral health care access that was restored and expanded in the Greater New Orleans area after Hurricane Katrina with the PCASG funds;
- Advance and sustain the medical home model begun under PCASG; and
- Transition the grant-funded model to a financially sustainable model over the long term that incorporates Medicaid, LaCHIP and other payer sources into participating providers' revenue base and helps participating providers to be competitive in the changing marketplace.

Program Strategy and Operations

Throughout FY 2012, DHH will pursue several strategies to further operationalize the GNOCHC demonstration. First, the Department will secure CMS approval of outstanding attachments to the special terms, conditions and deliverables during Phase 1 (October 1, 2010 through December 31, 2011) on which key elements of program operations depend key operations include administrative cost claiming protocol and audit and accounting protocol, the evaluation design and evolution plan for Phase 2 (January 1, 2012 through December 31, 2013).

Second, the Department will complete the start-up of program operations, consistent with the funding and reimbursement protocol approved by CMS on June 27, 2011, and the previously mentioned attachments and deliverables once approved by CMS. Finally, DHH will secure CMS approval of a waiver amendment to clarify the state's original intent for covered services (excluding pharmacy).

These combined strategies will enroll eligible individuals into the demonstration, providing in the program's first nine months basic health insurance coverage to 22,000 low income, uninsured adults—more than one-third of the total number of low income uninsured individuals served by PCASG during its three-year grant period. Further, enrolled providers eligible to participate in the demonstration will get continued access to a network of 18 PCASG organizations, including 36 delivery sites of GNOCHC-covered primary care, preventive care, behavioral health care, immunizations and vaccinations, care coordination, laboratory, radiology and specialty care services throughout the Greater New Orleans area.

Linking enrollees to a patient-centered medical home will provide financial incentives to participating primary care providers for achieving National Committee for Quality Assurance (NCQA) patient-centered medical home recognition and provide discrete payments for enrollee care coordination, including add-on interpregnancy care coordination services to improve birth outcomes for eligible enrollees.

These strategies will also transition a system of prospective interim payments based on historical PCASG grant award amounts to a system of retrospective encounter rate payments for a bundle of covered services provided to enrollees. Also, providers that previously reported limited encounter data in spreadsheet format under PCASG will transition to service-line level detail reported directly to the State's fiscal intermediary in standard Medicaid CMS-1500 format. Finally, participating providers can make investments to build the infrastructure necessary to successfully move from traditional funding sources for uninsured care (grants and patient cost sharing) to billing and revenue generation from third party coverage sources, such as Medicaid and commercial insurance.

DELIVERABLES

- Develop and issue provider manual based on CMS approved funding protocol and train providers on manual content ***August 2011***
- Complete provider enrollment tasks required for encounter data reporting and claims payment through the state's fiscal intermediary ***August 2011***
- Set encounter payment rates, begin encounter data reporting and begin encounter claim payments ***September 2011***
- Promulgate program rules consistent with CMS approved funding protocol, replacing emergency rules ***November 2011***

- Secure CMS approval of an evolution plan for Phase 2 of the demonstration, and implement plan beginning 1/1/12 *June 2012*
- Secure CMS approval of the administrative cost claiming protocol *September 2011*
- Secure CMS approval of the audit and accounting protocol *October 2011*
- Secure CMS approval of the evaluation design, and implement approved design *June 2012*
- Issue Request for Proposals for and award infrastructure investment payments *September 2011 and December 2011*
- Link enrollees to patient-centered medical homes *November 2011 through June 2012*
- Implement interpregnancy care coordination pilot *January 2011 through June 2011*

Medicaid Management Information System (MMIS)

Background

Louisiana's Medicaid Management Information System (MMIS) is the electronic system that processes 1.2 million claims and issues nearly $106 million in payments to health care providers each week. In place since 1984, the Department's current MMIS is antiquated and unable to make changes quickly. This hinders the implementation of any budget cuts or addition of new programs and makes it difficult to obtain detailed reports within a reasonable amount of time as requested by the Legislature and other entities.

In September, the Department began the process of planning for an MMIS replacement with the contracting of an Independent Verification & Validation (IV&V) vendor as recommended by CMS. IV&V vendors have experience with federal Medicaid Information Technology Architecture (MITA) and MMIS Certification Toolkit requirements for new MMIS replacement. The state performed it's MITA state self assessment to identify a roadmap to the innovative technology CMS requires for the new system, holding joint application design meetings with DHH subject matter experts as well as a provider association stakeholder input meeting in December 2008. In September 2009, there was a public hearing before the Joint Health and Welfare Committee to discuss the contents and release of the Solicitation for Proposals (SFP). In late 2009, DHH held more than 20 presentations from vendors who are leaders in Medicaid technology. Using all input, DHH, with the IV&V contractor, developed requirements for the proposal. The proposal was released in April 2010 as a Request for Comments (RFC) where any entity could provide comments to the proposed MMIS solution. After reviewing more than 800 comments, DHH revised the requirements and in November 2010 issued an SFP. The proposal included requirements to secure a Medicaid fiscal intermediary that could provide a web-based MMIS that complies with CMS MITA framework, which requires states to update and streamline their technology. DHH convened a team of more than 60 subject matter experts to review the four proposals received from leaders in the industry. The highest scoring vendor, CNSI, was selected. DHH is now moving into a period of contract negotiation that will ultimately provide Louisiana with a federally compliant and innovative system.

The current IV&V contract ends September 21, 2011. DHH has released an RFP and will be procuring a contractor to assist through the continued implementation of the replacement MMIS. The current MMIS fiscal intermediary contract ends December 31, 2011 with the option to renew for one year at a time through December 31, 2014. Louisiana must complete implementation by that time or risk federal funding for it's system.

Goal

Louisiana Medicaid will progress with implementation of a new MMIS that will incorporate the latest advancements in security, interoperability, data sharing, data mining, ease of use, expandability, flexibility, reliability and automation, while also being fully compatible with the expectations of transparency, accountability, quality of care and other health care initiatives. The replacement system will also allow the Department to make changes within days instead of months based on table-driven technologies. The new system will be appropriately integrated with the state HIE and provide recipients with easy access to their Medicaid claims information, ensuring that recipients are receiving the services for which Medicaid has been billed.

Comparison of a few major components of the existing system capabilities vs. proposed system capabilities

Existing System	Proposed System
Paper process with manual review	Totally electronic online application, with ability to accept scanned documents and electronically verify certifications and licenses
Core processing components more than 20 years old, cannot be easily modified and are duplicated across data silos	Federally compliant system that promotes interoperability, data sharing, data mining, flexibility, reliability and automation
100 percent paper provider enrollment process	Paperless electronic enrollment, using electronic signatures
Little verification of provider enrollment requirements	Electronic verification of ownership, exclusion and criminal background checks
Service authorizations are reviewed on paper by staff	Service authorizations will use clinical standards automated in electronic claims editing/processing
Enrollees have no access to their claims history	Web portal will allow enrollees to view their electronic claims data and demographics
No validation of home-based services	Verification system that validates worker is with the participant and the service is authorized using tools such as voice verification

Program Strategy and Operations

It is estimated that the development of the replacement MMIS will take three years. During the first 12 months (in FY 2012), there will be early implementation of two departmental initiatives to address fraud and abuse:

1) Visit Verification - a call-based verification system to validate that a direct service work is actually in the participant's home who is authorized to receive services; and
2) Electronic provider enrollment - electronic system that will do criminal background checks, verify certifications and licenses on an annual basis.

During the three years of design, development and implementation (DDI), the IV&V and fiscal intermediary contractor, with direction from DHH, will convene meetings with subject matter experts to collect requirements to build the MMIS. There will also be an extensive testing period of at least six months to ensure the claims are processed based on the documented requirements. The existing MMIS shall continue to process claims until the Department is assured the replacement MMIS can process claims appropriately.

A web portal will be developed to keep providers and the public apprised of the progress. Providers will be notified and provided training prior to implementation of the requirement to utilize visit verification and to re-enroll in Medicaid.

DELIVERABLES

- Negotiate contract with winning vendor ***September 2011***
- Execute MMIS fiscal intermediary contract ***November 2011***
- Release Independent Verification and Validation (IV&V) Contract Request for Proposals ***August 2011***
- Choose IV & V vendor and execute contract ***October 2011***
- DDI - collection of requirements. The requirements will start for all areas, but the main focus will be on provider enrollment and visit verification ***November 2011, January 2012, March 2012, May 2012***
- Development and implementation of a web portal for provider enrollment, training and updates on the project's status ***May 2012***

- Outreach and training related to provider enrollment and visit verification *January 2012- June 2012*
- Visit verification (proposed within eight months of contract start) *June 2012*

The Louisiana Behavioral Health Partnership (LBHP)

Background

Louisiana has long experienced spiraling costs, poor outcomes and limited availability of services in many geographic areas for mental health and substance abuse services. Though many efforts have been made to reform the system, Louisiana continues to rank poorly in national behavioral health comparisons. In addition to placing 49th for overall health in America's Health Rankings, the National Alliance on Mental Illness gave Louisiana a "D "in its most recent National Report Card. Even more troubling, though fewer than five percent of children in Louisiana are uninsured, only 7 to 14 percent with mental health disorders are receiving the services they need. Much of this can be attributed to four challenges in the current system:

- Fragmentation: The system lacks a clear single vision for how the state serves children and adults with significant behavioral health challenges;
- Financing: The state does not leverage and maximize state tax dollars effectively. Louisiana departments are not ensuring that Medicaid eligible children are receiving Medicaid services when eligible and that those eligible for Medicaid are identified and enrolled;
- Inconsistent Services: The state makes limited use of best practices and does so in geographic and bureaucratic silos only – failing to take those efforts statewide; and
- Poor Outcomes: Louisianians with behavioral health conditions have inadequate access to quality treatment and services, resulting in poor behavioral health outcomes.

Goal

By focusing on enhanced individual outcomes, the LBHP will improve the quality of care and behavioral health of 150,000 Louisiana citizens by June 30, 2013.

Program Strategy and Operations

In an effort to enhance service quality, facilitate access to care and effectively manage costs, the Department is working to restructure the current service delivery mechanisms by developing and implementing a comprehensive system for behavioral health services. The LBHP designed to provide an array of services to:

- All eligible children and youth in need of mental health and substance abuse care;
- Adults with substance use disorders;
- Adults with functional behavioral health needs, including:
  - Persons with acute stabilization needs;
  - Persons with serious mental illness (SMI);
  - Persons with major mental disorder (MMD);
  - Adult who have previously met the above criteria and need subsequent medically necessary services for stabilization and maintenance; and
- At-risk children and youth with significant behavioral health challenges or co-occurring disorders of mental illness and substance use (COD) in, or at imminent risk of, out-of-home placement.

A core component of this reform is the Statewide Management Organization (SMO). The SMO will assist with the reform efforts by:

- Fostering individual, youth and family-driven behavioral health services that are evidence-based;
- Increasing access to a fuller array of evidence-based and promising home- and community-based services that promote hope, recovery, and resilience;
- Improving quality by establishing and measuring outcomes;
- Managing costs through effective use of State, federal and local resources; and

- Fostering reliance on natural supports that sustain individuals and families in homes and communities.

Clients will have increased access to a more complete and effective array of behavioral health services and supports, leading to a reduction in the number of repeat hospitalizations, institutionalizations, out-of-home placements and emergency department visits. By June 30, 2012, an estimated 75,000 Louisianians will benefit from coordinated behavioral health care.

The Department's Office of Behavioral Health will implement the following strategies in establishing LBHP.

- Develop LBHP communication plan for OBH staff, providers and persons receiving services;
- Identify actuarial contract resources and establish ways to access the resources for LBHP implementation;
- Develop the IT business plan for LBHP and submit for approval inclusive of electronic behavioral health record;
- Submit amendments to the Louisiana Medicaid State Plan, including a 1915(i) State Plan amendment, as well as applications for 1915(b) and 1915(c) waivers to the Centers for Medicare Medicaid Services (CMS) for authorization to implement the proposed coordinated system of care for behavioral health;
- Develop and issue the Statewide Management Organization (SMO) Request for Proposal (RFP);
- Identify, define and submit service descriptions inclusive of eligibility, provider types, units of service and reimbursement rates to CMS for approval;
- Develop matrix for persons receiving services within LBHP, clarifying eligibility and identifying gaps;
- Identify qualified providers within LBHP, clarifying credential and/or certification requirements;
- Identify and assure availability of providers' training needs within LBHP;
- Develop training courses to meet the needs of required training in the event courses are not commercially available to meet the specific LBHP requirements;
- Develop credential and certification process for provider network within LBHP;
- Identify evidence-based assessments, programs and interventions for persons receiving services through LBHP; and
- Design and implement quality management plan for LBHP.

DELIVERABLES

- Establish a LBHP communication plan with on-going review and updating ***July 2011***
- Create a documented process for accessing Mercer's consulting services ***September 2011***
- Create a management plan for the SMO ***August 2011***
- Select winning SMO proposer ***September 2011***
- Create a cross systems matrix identifying populations of focus ***September 2011***
- Publish a provider requirements list inclusive of licensed and non-licensed providers by service type ***September 2011***
- Complete review and approval by CMS of waivers and state plan amendments ***October 2011***
- Complete implementation plan with SMO ***October 2011***
- Publish services manual for providers of service under the 1915(i) and 1915(b) waivers for the proposed focus populations ***October 2011***
- Implement SMO provider network development ***November 2011***
- Publish catalogue of required training, approved curriculum, process for approval of equivalent training ***November 2011***
- Complete training courses, curriculum and delivery process to assure provider compliance ***December 2011***
- Complete Medicaid and OBH required rulemaking for LBHP ***December 2011***
- Credential and certify providers ***January 2012***

- Complete and approve business plan for information technology Electronic Behavioral Health Record (EBHR) ***March 2012***
- Complete LBHP implementation ***March 2012***
- Verify SMO has enrolled a total of 54,680 individuals receiving services from addictive disorder and mental health clinics, and current mental health rehabilitation provider agencies ***April 2012***
- Verify SMO has enrolled an additional 20,446 individuals accessing behavioral health services for a total of 75,126 individuals ***June 2012***
- Conduct quality performance review of LBHP ***June 2012***

The Coordinated System of Care (CSoC)

Background

The current behavioral health system for youth in Louisiana consists of separate efforts by four different state agencies – the Office of Juvenile Justice (OJJ) and the Departments of Children and Family Services (DCFS), Health and Hospitals (DHH) and Education (DOE). This system is fragmented, results in duplication of behavioral health services and is not cost effective. Moreover, the system has inadequately provided behavioral health services for Louisiana's children and families in greatest need and at highest risk, resulting in too many out-of-home placements in a range of settings that are costly and often not very effective.

Left untreated, mental health disorders in children and adolescents lead to higher rates of suicide, violence, school dropout, family dysfunction, juvenile incarcerations, alcohol and other drug use and unintentional injuries. According to a study conducted by the National Center for Mental Health and Juvenile Justice (2006), 70 percent of youth in the juvenile justice system suffer from mental health disorders. Today, approximately 54,000 children and families have some form of contact with Louisiana's child welfare and/or juvenile justice systems. Annually more than 8,100 of these children receive foster care services and 8,700 children receive residential or probation and parole services through the juvenile justice system.

Recent estimates (Pires, 1996, 2002) indicate the following percentages of these youth in Louisiana need behavioral health services:

- 40 percent of those placed in DCFS foster homes;
- 70 percent of those in OJJ out-of-home placements;
- 20 percent of children and parents served in their homes by DCFS; and
- 50 percent of children and parents served in their homes by OJJ.

It is widely acknowledged that these children and families are currently served through a fragmented service delivery model that is not well coordinated, is often inadequate to meet their needs and is often difficult to navigate. State agencies are not currently pooling resources and leveraging the 'smartest' financing to provide a coordinated system of behavioral health services. This too often results in having Louisiana's children with the highest level of need detained in secure or residential settings, which are the highest cost services with the poorest outcomes.

The reality of Louisiana's current system was demonstrated in the financial analysis conducted by the state, which indicated that state agency spending for restrictive levels of care (including psychiatric hospital care, residential treatment and children in alternative school programs) was approximately $171 million and represented about 38 percent of total spending on behavioral health services.

CSoC efforts have been shown to address common problems found in other states and communities throughout the nation, including:

- Lack of home- and community-based services and supports;
- Patterns of service utilization that are racially/ethnically disparate and disproportionate;
- High cost administrative inefficiencies;
- Poor outcomes;

- Rigid financing structures; and
- Deficit-based/medical models, limited types of interventions.

(Source: Pires, S. (1996). Human Service Collaborative, Washington, D.C.)

On March 3, 2011, Gov. Bobby Jindal issued an Executive Order making Louisiana one of the first states in the nation to formally bring together the leadership of the four child-serving state agencies that serve this population to form a statewide CSoC for youth with significant behavioral health needs and their families. One initiative within the Louisiana Behavioral Health Partnership, CSoC will reduce the fragmentation and duplication in the delivery of behavioral health services; increase integration and collaboration across these four agencies in partnership with families and young people; and leverage dollars more effectively to enhance the available service array. The development of this comprehensive, community-based CSoC for young people with behavioral health challenges will allow Louisiana to support them in achieving better functioning across the basic areas of life, including safety, mental health, physical health, permanency, education attainment and self-sufficiency.

Goal

DHH, in conjunction with its partner agencies, will establish an effective statewide system of care capable of serving 2,500 youth and families with blended funding that is built on the CSoC model and values. In FY 2012, through the first phase of implementation, 200 children and families will begin receiving CSoC through comprehensive care plans.

This system will develop and finance services and supports for at-risk children and youth to keep them in their home community, in school and out of detention while achieving the best possible health and functioning in community settings. It will provide for the comprehensive behavioral health needs of at-risk children and youth and their caretakers by reinvesting current funds in the system into a more organized system of care. With this initiative, Louisiana is following a documented path of successful system reform.

Program Strategy and Operations

The Department's Office of Behavioral Health (OBH) has established a CSoC Governance Board to implement the initiative, which is comprised of staff from the partnering child-serving agencies (DCFS, DOE and OJJ), a family/consumer representative and other stakeholders to oversee CSoC implementation.

The CSoC team will engage in an educational and consensus-building process for providers and child-serving systems to create a common vision and understanding of the CSoC concept and what it means for Louisiana. This team will work with representatives from Louisiana Medicaid to ensure CMS approval, appropriate implementation and compliance for the Medicaid waivers and state plan amendments. After its selection through the LBPH initiative, the CSoC will partner with the Statewide Management Organization (SMO) to ensure the system of care is operationalized within the implementing regions with fidelity.

The CSoC team will assist the Phase I Act 1225 regions (regions 2, 7, 8, 9 and Jefferson Parish) with implementation of regional CSoCs that include establishment of regional community teams to support and guide their implementation efforts as well as wraparound agencies and family support organizations. They will guide state partners and other critical stakeholders through training and technical assistance to align with CSoC values and principles within their respective environments. By working with the Governance Board and standing committees, the team will be responsible for ensuring outcomes are defined and achieved.

DELIVERABLES

- Develop a refined organizational structure that ensures adequate staffing for the CSoC team, including creation of the Family Support Partner and other positions as needed ***September 2011***
- Conduct an Implementation Institute for 25 people representing the five Phase I regions to support their CSoC development and implementation efforts ***October 2011***
- Partner with OBH and the SMO to develop policies and procedures for eligibility into the CSoC ***September 2011***

- Have key staff positions in place for wraparound agencies in selected implementing regions *January 2012*
- Have key staff positions in place for family support organizations in selected implementing regions *January 2012*
- Finalize a core set of CSoC outcomes and indicators *January 2012*
- Define roles and responsibilities for provider participation in child and family teams and ensure providers are aware of these expectations *February 2012*
- Conduct education/discussion sessions reaching 200+ people for the internal CSoC team and other key partners (child-serving agencies, providers, families, youth, etc.) to support operationalization of CSoC values into practice *February 2012*
- Complete technical assistance and training to Phase I regions to support wraparound agency and family support organization readiness *March 2012*
- Ensure that 100 percent of the five wraparound agencies and family support organizations are ready for service delivery *March 2012*
- Ensure that 200 children and families are receiving CSoC services through the five implementing regions *June 2012*

1. Pires, S. (1996). Human Service Collaborative, Washington, D.C.

Pires, S. (2002). Building Systems of Care, A Primer., Human Service Collaborative, Washington, D.C.

Integrating Behavioral Health Business Practices and Treatment Approaches

Background

National studies (SAMHSA, 2006; Kessler et al., 2005) have shown that there is a high rate of prevalence of persons who suffer from both mental health and substance use disorders. Research (Compton et al., 2000; Sacks et al., 1997) has revealed that approximately half of persons seeking treatment for a behavioral health condition suffer from co-occurring mental health and substance use disorders. These statistics vary depending on research methods, but the current standard of care is to "expect" that individuals seeking treatment for either a mental health or substance use disorder actually suffer from both. Research (Charney et al., 2001; Drake et al., 1998, 1997; McClellan et al., 1993) has further proven that when persons with co-occurring disorders are not treated for both disorders, their outcomes and progress in treatment are poor. Given the high prevalence rates of co-occurring disorders, the standard for behavioral health care is an integrated model where a person is able to receive comprehensive and seamless care for both mental health and substance use disorders. The integrated models of care have proven to be more efficient, less redundant and produce better outcomes, such as reduced reliance on hospitalization and longer periods of symptom remission.

Unfortunately, many state-supported mental health and addictive disorder providers, including those in Louisiana, have been indirectly encouraged to provide separate tracks of care. Historically, persons with co-occurring disorders have been told by mental health providers that they need to get "clean" before starting mental health treatment, or have been told by addictive disorders providers that they cannot receive mental health care or take medications while undergoing treatment for addictive disorders. This has presented a situation where state addictive disorders and mental health clinic operations have maintained separate leadership, separate funding and separate service delivery operations from one another. In an effort to address this issue, Louisiana has worked toward developing an integrated behavioral health delivery system that is able to effectively manage persons with co-occurring disorders.

In the 2009 Legislative Session, Act 384 authorized DHH to merge the Offices of Addictive Disorders and Mental Health to form a single Office of Behavioral Health (OBH). This merger combined and fully integrated both the administrative and service delivery functions of each office. The addictive disorders and mental health programs merged local management and fiscal activities, and reorganized clinical service delivery. In the initial phases, the mental health and addictive disorders clinics began the first step of moving mental health and addictive disorders staff together into unified "behavioral health" clinics. The ultimate goal for these clinics is to develop integrated provider teams

that are capable of treating the wide spectrum of persons with co-occurring disorders.

These service system changes come at a critical time as the state moves toward a coordinated care model through the Louisiana Behavioral Health Partnership (LBHP). The system changes for an integrated care delivery system align and complement the necessary changes needed to meet the standards for the Medicaid and coordinated care environment. This emerging delivery system has two significant departures from the old delivery model: services are delivered in an integrated fashion, and services are coordinated by a statewide management organization.

Goal

OBH will develop new business and treatment processes that account for integration of mental health and addictive disorder services and managed care delivery.

Program Strategy and Operations

OBH will first conduct a streamlined overview of funding sources and identify policy and protocol mandates for each source. Working within that context, OBH will take specific steps to continue the integration of services at publicly operated clinics. This will include implementation of a fully electronic health record system, standardization of operational procedures and development of financial efficiency and accountability standards. OBH will work closely with local institutes of higher education to explore and facilitate the implementation of evidence-based practices. This fall, all OBH-run clinics will embark upon the accreditation process.

OBH will work to convert all clinics to Medicaid Access Centers by the beginning of 2012. In the Spring, OBH will develop and commit to a timeline for the clinical integration of publicly operated facilities, as well as a needs assessment for the necessary workforce training. OBH will then initiate a transitional licensure plan until new legislation can be crafted to account for behavioral health integration. Simultaneously, OBH will develop marketing and outreach strategies for each publicly operated clinic. By the end of the year, all OBH-operated clinics will be using a newly crafted Business Operational Process Manual.

DELIVERABLES

- Create a document that provides an overview of funding mandates and sources ***October 2011***
- Develop a strategic plan for implementation of electronic health records for OBH Clinics ***September 2011***
- Begin accreditation process for publicly operated clinics ***November 2011***
- Convert publicly operated clinics into Medicaid Access Centers ***January 2012***
- Give behavioral health providers access to workforce development opportunities that are in line with the state's current behavioral health goals and objectives ***January 2012***
- Implement a financial efficiency and accountability plan for state-operated clinics that projects revenue based on service delivery ***January 2012***
- Public clinics will begin using uniform treatment guidelines ***March 2012***
- Develop written uniform policies and procedures for the delivery of integrated services at all state run clinics ***March 2012***
- Develop a marketing outreach plan and timeline for public clinics ***March 2012***
- Develop a plan and timeline for the integration of primary care with publicly operated clinics ***March 2012***
- Provide behavioral health providers with exposure to evidence-based practices/ evaluation techniques and access to implementation strategies ***July 2012***
- Have all publicly operated clinics using a newly crafted Business Operational Process Manual ***July 2012***

Integrating Public Health and Primary Care

Background

In 2010, Louisiana ranked 49th out of 50 states in America's Health Rankings largely because of its high burden of chronic diseases and barriers to accessing care. Some of these factors included:

- 33.9 percent of population is obese (49th in the nation);

- 35.6 percent of population has hypertension (46th in the nation); and
- 18 percent of the population lack health insurance (41st in the nation).

In addition, Trust for America's Health found that Louisiana ranked in the top five for many preventable conditions in 2011, including:

- #2 in prevalence of low birth weight babies
- #4 diabetes rate
- #2 syphilis rate
- #4 chlamydia rate

DHH, through its Office of Public Health (OPH) provides preventive personal health care services through 68 parish health units (PHUs) located in nine regions throughout the state. Although each region contains at least one federally qualified health center (FQHC), a rural health clinic (RHC) and numerous private practitioners, a formal mechanism that ensures coordination of services with primary care providers and links residents to patient-centered medical homes does not exist.

In December 2010, the PHUs underwent a combination of facility closures (in Orleans Parish) and targeted operational reorganization in select parishes across the state. Many PHUs now share staff and coordinate services so that one PHU is open for three days per week and the partner PHU is open for two days per week. The assessment used to identify PHUs for reorganization evaluated whether other health care entities were located in close proximity and in some cases providing duplicative services. Engaging these health care partners in redesigning the system will provide opportunities to coordinate and integrate services to improve delivery of care to Louisiana residents.

Another key consideration in the transformation of the current public health delivery system is the advent of Coordinated Care Networks (CCNs), DHH's solution to improving Medicaid. CCNs will provide medical homes for Medicaid recipients and deliver high-quality coordinated health care services that achieve measurable improvements in population health.

Currently, OPH administers 50 distinct public health programs and 72 federal grants. Each of the public health regions must use and leverage existing resources to maximize efficiencies in delivering public health services. These resources include parish governments that provide building space and shared staffing between OPH and local governments for the provision of public health services. To better determine and prioritize needs and opportunities, OPH will conduct community health assessments that will identify the health profile, health needs and resources within each community. The community health assessments will allow OPH to identify health disparities; target populations at risk for negative health outcomes; and pinpoint barriers to and opportunities for change.

There are at least three public health-primary care integration models currently operating in Louisiana.

Co-location: PHU and primary care providers are co-located in the same physical facility, but operate as separate entities, i.e. two distinct points of entry. (Example: Jefferson Parish PHU and Daughters of Charity Health Center in Metairie, LA)

Parish Health Unit with Primary Care Services: PHU offers a primary care service through OPH-employed or contract providers, i.e. single point of entry (Example: Prenatal services in Ouachita PHU)

Federally Qualified Health Center with PHU Services: Federally qualified health center offers preventive personal health care services traditionally offered in the PHU and serves as the parish PHU through contractual agreements with OPH. (Example: St. Charles Community Health Center in Luling, LA)

As state and federal health care reform efforts take effect, it is important local, state and national stakeholders are actively engaged in the process of identifying the models that are most appropriate for each community and that will best position Louisiana to improve its public health and primary care delivery system.

Goal

OPH will increase access to comprehensive, high quality primary care services for all Louisianians by:

- Increasing the number of clinics statewide that provide both primary care and preventive

personal health care services from five to 10 in FY 2012; and

- Executing CCN provider agreements in all regions in FY 2012.

Program Strategy and Operations

OPH will complete an assessment that identifies the areas of need for health care professionals to provide preventive and primary care services coupled with the available resources (i.e., PHUs, FQHCs, school-based health centers, etc). This assessment will strengthen partnerships with entities within this service area to collaboratively design a service delivery model that encompasses both preventive and primary care services in underserved communities. This model will ensure that community health needs in the areas of chronic diseases; Tuberculosis (TB) treatment and communicable disease control services; family planning services; sexually transmitted disease (STD) services; HIV/AIDS services; women, infant and children (WIC) nutrition services; and immunizations are adequately addressed and are provided within a medical home.

OPH is developing an integrated strategy to transition essential public health services into the private sector of communities that have adequate resources and infrastructure to sustain the services. By facilitating communication, coordination, and collaboration of preventive and primary health care entities, OPH strives to avoid duplication of services, achieve optimal quality in health services and demonstrate measurable improvements in population health in Louisiana. OPH will also include stakeholders in the process by providing a platform for stakeholder input with its partners, including the Louisiana Primary Care Association (LPCA) and Louisiana Rural Health Association (LRHA).

CCNs will exist in each region. These networks of providers will provide a medical home, which will deliver high quality coordinated health care services for Medicaid recipients. OPH will redefine its role as safety net provider for some services or in some geographic areas of the state depending on the adequacy of the number of providers in the network.

DELIVERABLES

- Conduct a summit with LPCA/LRHA for the purpose of establishing stakeholder buy-in from their respective memberships in transitioning the delivery of personal health services ***October 2011***
- Complete the health care access resource assessment for 36 parishes in primary care and mental health professional shortage areas ***October 2011***
- Create and implement one standardized agreement or contract with FQHCs and RHCs to provide personal health services ***January 2012***
- Implement a pilot initiative based on delivery of personal health services by FQHCs/RHCs in a priority area of the state ***March 2012***
- Execute provider agreements with CCNs in all areas of the state ***March 2012***
- Execute at least two agreements in prioritized communities based on need for services with FQHCs/RHCs ***May 2012***

Louisiana Birth Outcomes Project

Background

Louisiana continues to fail in most reports, rankings and studies of health status and health systems performance tallied by organizations such as the United Healthcare Foundation, the Annie E. Casey Foundation's Kids Count Data Center and the March of Dimes. For birth outcomes, the state's rankings are particularly worrisome. Louisiana ranks 48th nationally in infant mortality and preterm birth, and 49th in the percentage of low and very low birth weight babies, according to the National Center for Health Statistics. Health disparities define and shape these poor rankings as indicated by elevated poor outcomes in Louisiana's African-American population.

While Medicaid finances nearly 70 percent of births in our state, among the highest in the nation, Medicaid eligibility ends 60 days postpartum for 73 percent of women whose maternity care was covered by Louisiana Medicaid. Due to this lack of interconception care, many women will have a subsequent Medicaid-covered birth with a high cost and adverse pregnancy outcome before their medical and psychosocial risks are addressed.

Diabetes, hypertension, sexually transmitted diseases, obesity, smoking, heavy alcohol use and depression, for example, all affect a woman's long-term health and can contribute to high-risk pregnancies and babies being born too small, too soon or sick.

National surveys indicate that opportunities for preventive care and health promotion among women are largely missed. The Kaiser Family Foundation 2005 surveyed women between 18 and 44 years of age and found that just over half of the women had spoken with a health care provider in the previous three years about diet, exercise or nutrition; and less than half had discussed calcium intake, smoking and alcohol use. Smoking is an important determinant of health status and a major contributor to prematurity and low birth weight. Twenty-two percent of women in Louisiana between 18 and 44 years of age reported smoking in 2009, a two percentage point increase over 2008. Drinking alcohol during pregnancy, particularly binge drinking, can cause birth defects and developmental delays. In 2009, 13 percent of Louisiana women between 18 and 44 years of age reported binge drinking in the past month. In addition to substance use issues, women in Louisiana also suffer with mental health issues, including depression. Results of screening programs show the rates of clinically significant depression symptoms in pregnant and postpartum women are approximately 15-20 percent in Louisiana.

Providing better access to preconception care, improving screening for tobacco and alcohol and building a better network of treatment services are all vital steps to improving the health of women in Louisiana. National recommendations from the Centers for Disease Control and Prevention Select Panel on Preconception Health and Health Care and evidence-based recommendations on the content of preconception care provide a framework of changing the paradigm of primary care for women of childbearing age. Preconception care includes care before a first pregnancy or between pregnancies (commonly known as interconception care). The purpose is to provide health promotion, screening and interventions for women of childbearing age to reduce risk factors that might affect future pregnancies. The Interconception Care Project at Grady Memorial Hospital in Atlanta demonstrated how these components, delivered through a patient-centered medical home, and intensive case management improve the health of women, increase pregnancy interval and improve pregnancy outcomes.

Compounding Louisiana's poor birth outcomes is the financial burden associated with high labor and delivery costs. The average cost for premature infants in Louisiana is $33,000 compared to a national average of $4,000 for term newborns (March of Dimes, 2010). With approximately 7,000 premature births covered by the Medicaid program each year, the excess costs to the state potentially exceed $200 million annually. In many hospitals, unnecessary inductions and cesarean sections occur before 39 weeks gestation and lead to increases in neonatal intensive care (NICU) admissions. These inductions not only lead to increased costs, but overwhelming evidence also indicates they harm mothers and babies. Organizations including the American College of Obstetricians and Gynecologists (ACOG), the March of Dimes and the American Academy of Pediatrics have all prioritized this issue. Significant improvements in ending elective deliveries without medical indication prior to 39 weeks gestation have been demonstrated by Intermountain Healthcare in Utah and the Seton Family of Hospitals in Texas. Louisiana's own Woman's Hospital in Baton Rouge and East Jefferson General Hospital in Metairie have seen marked perinatal improvement, in large part due to their efforts to track and monitor data.

Goal

To improve birth outcomes in Louisiana, the Birth Outcomes Initiative (BOI) will:

- Create a culture of continuous quality improvement and safety in Louisiana's birthing hospitals;
- Increase DHH data capacity and performance measurement of maternity care and increase accountability for clinical outcomes;
- Assess and improve the behavioral health of Louisiana's pregnant women; and

- Improve preconception and interconception care coordination to improve the health of Louisiana women.

Program Strategy and Operations

Since August 2010, the Department has engaged community members and key stakeholders to determine evidence-based practices that can be implemented in Louisiana to improve women's and infant health. In April 2011, with heavy stakeholder input, BOI finalized its strategic plan and will continue to execute steps necessary to improve patient safety, data capacity and transparency, behavioral health screening, referral and treatment and care coordination for high-risk women.

39-Week Initiative: To achieve greater patient safety, hospitals must implement evidence-based best practices, such as ending medically unnecessary deliveries prior to 39 weeks. In July 2011, the Secretary asked all birthing hospitals in Louisiana to end these deliveries. Hospital-level reporting and the creation of hospital and provider consensus around proven protocols and statewide quality measures will help ensure improved outcomes. BOI has created a perinatal quality collaborative throughout the state's leading maternity care hospitals that will focus on labor and delivery and NICU quality improvement. This year-long project began in July 2011 with 20 major maternity hospitals and is led by DHH and the Institute for Healthcare Improvement (IHI). Best practices learned from this experience will be shared with and used by all birthing hospitals in Louisiana.

Birth Report Cards: Performance measurement systems are being put in place to determine whether interventions are successful and to ensure transparency in practice. A perinatal data and measurement portal is being created with the idea that reporting could reach beyond birth outcomes into other metrics. Data will be shared with appropriate entities tasked with generating the statewide annual perinatal report card. Collection of data as well as voluntary reporting of data from hospitals must be achieved. BOI will also work to establish a high risk database that could be used by physicians to aid in patient care and in determining which women might benefit from 17P administration and to ensure that women at elevated risk of having a poor birth outcomes based on behavioral factors, such as cigarette smoking and alcohol consumption, receive adequate screening and treatment.

Behavioral Health Screening: For measurable impacts in behavioral health to be achieved for Louisiana's Medicaid-eligible women, a statewide system of screening, referral and treatment for the highest risk pregnant women is being implemented. Private providers will be reimbursed for performing a behavioral health screen and a brief intervention for each pregnant woman in Medicaid. BOI and Medicaid are currently developing an online submission mechanism for the screening tool. This will allow DHH to collect adequate data on behavioral health needs of pregnant women in Medicaid and track behavioral health outcomes through data collection and monitoring. Provider outreach and training on the use of the new screening tool will be completed. Office of Public Health regional staff can assist with medical and non-medical community outreach in each of DHH's geographic regions. Partnerships with existing programs such as the Tobacco Quit Line and Louisiana's Tobacco Control Program are currently being strengthened and leveraged to ensure that providers are adequately trained and that women are able to receive appropriate treatment services.

Interconception Care: Finally, the BOI will seek to improve preconception and interconception health for women at high risk of poor birth outcomes in Louisiana. Experts have identified evidence-based interventions such as assistance by a care coordinator and home visitation that can be delivered to women at high risk of a poor birth outcome to reduce the chances of an adverse outcome for mother and baby. The purpose is to provide care coordination, health promotion, screening and interventions for women of childbearing age to reduce risk factors that might affect future pregnancies. Currently, BOI is working to institute an interconception care program in the Greater New Orleans Community Health Connection (GNOCHC) program. If approved by CMS, the program will provide access to interpregnancy

primary care health services for eligible women who have previously delivered a premature, stillbirth, low or very low birth weight infant in the Greater New Orleans area. To increase opportunities for preconception and interconception care statewide, the BOI and Medicaid will work with Coordinated Care Network providers as they develop and implement interconception care programs for their enrollees.

DELIVERABLES

- Publish an online statewide behavioral health screening tool through Medicaid *January 2012*
- Launch a care coordination program in GNOCHC program *January 2012*
- Provide technical assistance to and collaborate with Coordinated Care Networks as they plan and implement interconception care programs statewide *January 2012, March 2012, May 2012*
- Create and share Louisiana's Birth Report Card with demonstration group public reporting planned for late 2012 *November 2011*
- Significantly reduce non-medically indicated deliveries prior to 39 weeks gestation by having policies in all Louisiana birthing hospitals *January 2012*
- Create a hospital IHI perinatal quality improvement collaborative that will culminate in Louisiana birthing centers of excellence *July 2011, October 2011, June 2012*
- Create a hospital Neonatal Intensive Care Unit quality improvement collaborative that will culminate in Louisiana birthing centers of excellence *October 2011, January 2012, October 2012*

Promoting Independence through Community-Based Care

Redesigning the Community-Based Long Term Care Infrastructure

Background

Louisiana's comprehensive plan for long-term care reform, Louisiana's Plan for Choice in Long-Term Care, is a strategic blueprint for system rebalancing and has served as Louisiana's "Olmstead Plan." The 1999 U.S. Supreme Court Olmstead decision ruled that unnecessary institutionalization could be a form of discrimination under the Americans with Disabilities Act (ADA). Many of the actions called for in the Plan for Choice are well-established best practices that national researchers and the Centers for Medicare and Medicaid Services (CMS) have identified as hallmarks of a right-balanced long-term care system.

Louisiana currently spends about 27 percent of its Medicaid long-term care funding on older adults and people with adult onset disability on home- and community-based services ($314 million for community-based services in FY 2011 versus $849 million for nursing facility care). Even though Louisiana is serving a much larger number of people in the community than it did 10 years ago, DHH's current waiting list for community-based services includes 20,000 people – and the aging of Louisiana's population means demand will continue to grow.

As the transition from institutional (nursing home) care to home- and community-based services (HCBS) continues to expand in the coming years, DHH's Office of Aging and Adult Services (OAAS) must face the challenges of ensuring quality, maintaining financial sustainability and implementing HCBS program improvements. Over the past several years, OAAS received several federal systems change and systems transformation grants that have allowed it to plan and develop Transformational Priorities to address key issues, including:

Heavy Reliance on 1:1 In-Home Care: Three years ago, OAAS inherited an HCBS program that included few alternatives to in-home, one-to-one care. Heavy reliance on in-home workers encourages service dependency and displacement of natural supports, leading to unnecessarily expensive plans of care and violations of federal cost-neutrality requirements.

Provider Capacity: Louisiana has one of the lowest nursing facility reimbursement rates in the country (AARP, Across the States: Profiles of Long-Term Care and Independent Living, 2009). The nursing facility rates determine the cost neutrality of aggregated annual budgets for community-based care recipients. When combined with overuse of 1:1 assistance,

rates paid to home- and community-based service providers must also be low, negatively impacting provider capacity. There is also an insufficient pool of long-term care workers in all areas and rates of worker pay are generally low.

Support Coordination Competency/Capacity: The private system of support coordination (i.e., case management) does a poor job of providing timely access to services and performing its core functions of assessment and care planning. This problem has been exacerbated recently by the large number of nursing home transitions that support coordinators are now planning and facilitating. Capacity challenges also exist as several regions lack a sufficient number of effective case management agencies.

IT Capacity: Many key OAAS business processes are still performed on paper, including participant assessment and plan of care development. This long-standing issue inhibits DHH's ability to provide high-quality services.

Goal

DHH will organize and maintain a delivery system for home- and community-based services to achieve quality and prevention outcomes that meet or exceed outcomes for residents in nursing facilities as measured by national Health Effectives Data and Information Set (HEDIS) and Agency for Healthcare Research and Quality (AHRQ) standards. At the same time, these services will be provided at an average annual per-person cost at or below 50 percent of the average annual per-person nursing facility cost, a reduction from the current 54 percent. In real dollars, that would reduce per-person costs for home and community-based services from approximately $21,500 to $20,000 per year.

Program Strategy and Operations

Implementation of Community Choices Waiver: The Community Choices waiver will replace the current Elderly and Disabled Adult (EDA) waiver program with a broader array of cost effective services designed to increase or maintain independence. The new services to be made available will include skilled therapies, in-home monitoring systems and assistive technologies, home-delivered meals, caregiver respite, and nursing. There will also be a new, data-driven approach to quality assurance under the Community Choices waiver and additional controls over expensive services like home accessibility modifications.

Support Coordination Improvements: In conjunction with the Community Choices waiver, OAAS is implementing an extensive competency-based, mandatory training program for all support coordinators. Training includes testing and certification of competency in assessment and care planning. This certification training will be coupled with an automated support coordination monitoring process and tool that will allow OAAS to assess and improve program quality and readily report program compliance and outcomes. Performance agreements have been executed with all support coordination agencies to effectively remedy poor results and create performance incentives. OAAS will provide an extensive program of technical assistance to provider agency administrators, executives, supervisors and staff.

Adult Residential Care (i.e., assisted living) Waiver: OAAS planned to implement an Adult Residential Care waiver that will provide a residential alternative for individuals whose needs cannot be met cost-effectively in the community and who require a degree of assistance and supervision that might otherwise lead to more expensive nursing facility placement. This waiver was denied by CMS on August 24, 2011 and DHH is currently evaluating alternatives to move forward with providing this long-term care option for low-income Louisiana residents.

Consumer Direction within OAAS Community-Based Programs: The Community Choices waiver will include a consumer-directed option, allowing participants greater budget flexibility and the ability to recruit, hire and fire their own care workers. Participants in consumer direction will be able to negotiate worker salaries without going through a provider agency. Consumer direction is recognized as one tool for addressing the limited pool of available long-term care workers. This option will be expanded to other services as resources permit.

Automation and IT Improvement: OAAS has recently contracted for development of an electronic plan of care and participant tracking system. Web-based automation of the plan of care will allow the state to more readily review, approve and process plans of care. This will speed access to services and will allow for more effective monitoring of access and support coordinator performance.

Resource Allocation and Benefit Right Sizing: OAAS has successfully implemented an acuity-based resource allocation system that sets individual budget and service maximums based on a person's relative level of disability and acuity. OAAS has also reduced the maximum allowable cost for an individual's plan of care and is in the process of reducing the personal care program maximum from 42 to 32 hours per week. These changes saved $19 million in fiscal year 2010; and in FY 2011, OAAS was able to serve 5,000 more people for $2 million less than in fiscal year 2009. The average waiver expenditure ($26,629 thousand per year) is still higher than average costs in states like Arkansas and Texas that are successfully using community-based waivers to avoid institutionalization. Louisiana's personal care program maximum remains higher than the national average of 28 hours per week. These adjustments will put the personal care program more in line with national norms and allow the state to serve more people with available funds. Close monitoring of these programs show no increase in nursing home admissions since the implementation of these changes.

DELIVERABLES

- Implement Community Choices waiver ***October 2011***
- Implement Consumer Direction in conjunction with Community Choices waiver ***October 2011***
- Have approximately 300 support coordinators and support coordinator supervisors complete assessment and care-planning training, competency-based online and field testing and be certified to perform assessments and care planning ***September 2011***
- Implement annual performance and quality assurance monitoring of the 28 support coordination agencies currently under performance agreement with OAAS ***April 2012***
- Complete system design document for electronic plan of care ***October 2011***
- Reduce average annual per person HCBS cost to below 50 percent ($20,000) of average annual per-person nursing facility costs ***June 2012***

Right Balancing Institutional and Community-Based Long Term Care

Background

Louisiana's Medicaid long-term care services have historically been among the most institutionally biased in the nation. Louisiana has made considerable progress since 2000 when it ranked 49th in percentage of spending for community-based vs. institutional long-term care for the elderly and disabled. By 2009, Louisiana's ranking had risen to 14th – a significant accomplishment (Thomson Reuters, Medicaid Long Term Care Expenditures, 1996-2009). However, Louisiana still ranks second in the number of nursing facility beds and sixth in the number of nursing facility residents per capita over the age of 75 (AARP, Across the States: Profiles of Long-Term Care and Independent Living, 2009). Louisiana also has one of the lowest nursing home occupancy rates in the country at 72 percent. These facts coupled with the growing waiting list (now at 20,000 people) for community-based services point to the need for continued right-balancing. This shift is also supported by several other important factors.

Cost Effectiveness and Outcomes: Louisiana's home- and community-based (HCBS) long-term care programs for older adults and people with adult onset disability provide high quality care at low costs. In 2011, HCBS programs for older adults and people with adult onset disability cost $12,919 less per person than Medicaid nursing home care. DHH's HCBS programs also perform as well or better than institutional services on Agency for Healthcare Research and Quality (AHRQ) and Healthcare Effectiveness and Data Information Set (HEDIS) measures. Additionally, surveys conducted with a random, statistically valid sample of recipients show high levels of satisfaction with DHH's community-based programs.

Consumer Preference, Demand and Utilization: While nursing homes are an important part of the long-term care provider community, there is evidence of a strong consumer preference for home- and community-based services over nursing home care. Public opinion surveys conducted by the Kaiser Family Foundation, most recently in 2007, have found that if consumers required long-term care, 53 percent would opt for care in their home, 17 percent would choose assisted living and 21 percent would prefer to move in with family.

Public perception and experience are reflected in declining nursing home utilization, which has decreased nationally by 26 percent since 1974. In Louisiana, nursing home utilization declined 9 percent in the last five years while the waiting list for community-based programs has increased to 20,000 people.

Legal: The U.S. Supreme Court's 1999 decision in Olmstead v. L.C. noted that "confinement in an institution severely diminishes the everyday life activities of individuals – including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." The ruling found that unnecessary institutionalization could be a form of discrimination under the Americans with Disabilities Act (ADA). Louisiana was one of the first states to be sued under Olmstead. The settlement agreement in Barthelemy vs. Louisiana Department of Health, which expired in December 2010, mandated the implementation of the Long-Term Personal Care Services program as a Medicaid state plan "entitlement," and while in effect, determined many features of the system of Medicaid-funded home- and community-based services in Louisiana. Louisiana currently faces a new legal challenge regarding reduction to the maximum number of personal care hours allowed in the Long-Term Personal Care program and remains at-risk for future Olmstead-related suits and Department of Justice actions.

Goals

Louisiana is working toward the national average (34 percent in 2009) in percentage of long-term care spending for community services versus nursing home services. It also seeks to serve at least half of elderly/adult long-term care recipients in the community. For FY 2012, OAAS aims to increase the percentage of long-term care spending on community-based long term care to 30 percent and serve at least 45 percent (projected to be about 20,000 people) of OAAS long-term care clients in community-based settings.

Program Strategy and Operations

DHH's solution to meeting Louisiana's rebalancing objectives involves the following strategies:

Expand Implementation of Money Follows the Person (MFP): OAAS has transitioned more than 99 individuals out of nursing homes under MFP (56 of them in the current calendar year) with another 73 in the process of being transitioned and 40 awaiting available housing. All who have transitioned are being served at a lower cost to the state. DHH recently received an additional $14 million for MFP and is in the process of expanding those efforts, including inclusion of behavioral health services.

Pursue 1915(k) Authority for Personal Care Services: Provisions in the Affordable Care Act (ACA) provide an additional 6 percent match for personal care services provided through a Medicaid mechanism or "authority" referred to as 1915 (k). OAAS will evaluate the provision of personal care services through this new authority as an alternative to the current personal care program.

Explore Options for Managed and Coordinated Care: According to recent legislative mandate, OAAS will work to develop a managed care pilot for long-term care. OAAS's current experience with managed care approaches is limited to its two Program for All-inclusive Care of the Elderly (PACE) programs in New Orleans and Baton Rouge. PACE is a well-established nationally standardized model for combining acute and long-term care delivery via a capitated payment combining Medicare and Medicaid funding. Such an approach that includes both HCBS and

institutionally based care, but on a larger scale than PACE, could do much to align utilization and payment with the goals of right-balancing. Opportunities under ACA for improved coordination of acute, long-term and behavioral care for dual eligibles and those with chronic conditions will also be considered, as will any resources that become available to fund the necessary research and development work that would have to be performed prior to implementing any such program.

DELIVERABLES

- Complete hiring of nine MFP regional coordinators to implement MFP statewide *September 2011*
- Exceed the 2011 MFP benchmark by transitioning at least 90 individuals from nursing homes into the community *December 2011*
- Add behavioral health services to Louisiana's MFP operational protocol and submit for CMS approval *December 2011*
- Seek CMS approval to include Long-Term Personal Care Services as a qualified community service for Louisiana's MFP demonstration *January 2012*
- Increase number of people served in HCB programs from 16,000 to 20,000 *June 2012*

Employment First Initiative for Citizens with Developmental Disabilities

Background

"Employment First" is used to describe how state and local systems across the country articulate the values and philosophy which secure employment services and supports available for individuals with disabilities. An "employment first" approach means that integrated individual employment is offered before other service options and that community employment is supported as the priority outcome in policy, practice and quality management. This means promoting a focus on real jobs and real wages in real business settings. Louisiana is one of 25 states participating in the State Employment Leadership Network (SELN), a joint initiative of the National Association of State Directors of Developmental Disabilities Services and the Institute for Community Inclusion at University of Massachusetts. SELN is a cross-state cooperative venture of state developmental disability agencies that are committed to improving employment outcomes for adolescents and adults with developmental disabilities.

In order to advance the growing national momentum to focus on integrated employment as a desired outcome for people with developmental disabilities, the Department's Office for Citizens with Developmental Disabilities (OCDD) partnered with Medicaid on the Medicaid Infrastructure Grant (MIG) to create the Five-Year Work Pays Strategic Plan in 2010. Out of this initiative, the Work Pays Coalition formed to become the group tasked with the implementation of the strategic plan. The goals for Louisiana are to see an increase in people with disabilities employed in careers of their choice and a workforce that is accessible for all people with disabilities. Oversight of the plan development was provided by the Louisiana Workforce Commission.

Louisiana is in the process of refocusing resources to support individuals in competitive employment in the community, and make integrated employment the primary option for all individuals with disabilities. OCDD is the first agency in Louisiana to make the transformation to an Employment First agency. OCDD has formed an Employment First Workgroup. The workgroup consists of partner agencies, individuals with developmental disabilities and advocates, and it assists in reviewing OCDD policies and procedures to ensure that they are supporting the philosophy of Employment First. Additionally, the work group offers recommendations to support OCDD during this time of transformation.

Of the 2,746 adults served by OCDD in employment and day supports in FY 2009, 1,288 received integrated employment services. Currently, the vast majority of individuals receiving integrated employment services from OCDD are in group-supported employment placements (Butterworth et al, 2011). Additionally, data from OCDD's participation in the 2009-2010 National Core Indicators Project employment survey found that of the 267 adults living in the community who were surveyed, only 10.9 percent were actually employed in integrated jobs. Further, only 20 of the

267 adults were in individual jobs in the community (unpublished data, Human Services Research Institute (HSRI) and Institute for Community Inclusion, 2011).

Goals

In June 2011, OCDD released its position statement on Employment First, stating "Employment will be the primary outcome for all persons receiving OCDD services who are of working age." Over the next five years, OCDD will increase the number of persons in individual integrated employment by 850, with 75 in the first year. By June 30, 2012, OCDD will develop a comprehensive plan for implementing and expanding individual integrated employment in the second and successive years. By June 30, 2012, OCDD will develop proposed policy changes to support individual integrated employment.

Program Strategy and Operations

Employment, characterized as typical jobs with competitive wages that are fully integrated in the workforce, will be the primary outcome for all persons receiving OCDD services who are of working age. This will be accomplished through a five-year project beginning with building foundation for improvement in strategic partnerships and collaboration with stakeholders and continuing through successive years to rule and policy revisions and, finally, to full statewide deployment of best practices in individual integrated employment. Strategic partnerships include the Employment First Workgroup, Louisiana Workforce Commission, the MIG, the Alliance for Full Participation and the Work Pays Coalition as well as Louisiana providers and advocates. OCDD will work to develop additional new partnerships as the project progresses. Technical assistance and guidance from the SELN will continue to ensure OCDD is aware of national best practices and trends surrounding Employment First. Data will be collected each year to monitor progress.

The first year will be used to lay Employment First's foundation and will include the development of a comprehensive plan that will be used to guide Employment First implementation. OCDD will build partnerships with approximately five provider agencies with a focus on securing individual integrated employment for 75 people to facilitate the development of pilot projects for year two. Additionally, OCDD will work with SELN to collect baseline data by defining terminology and metrics that accurately evaluate current employment trends for people with developmental disabilities in Louisiana. Information regarding wages earned, hours worked, places of employment, hours in the community and other pertinent information will be collected on the individuals supported by OCDD. Policies, procedures, service definitions and rates will be reviewed to ensure they support Employment First. Education and training on Employment First will be provided to individuals, families, providers and support coordinators.

Strategies for FY 2012 include:

1. Creating and continuing partnerships with stakeholders and local and national organizations;
2. Assessing opportunities and barriers relative to individual integrated employment;
3. Training providers, families and self advocates on Employment First Initiative;
4. Planning pilot projects for year one implementation of best practices;
5. Proposing changes in rule and policies to support individual integrated employment; and
6. Expanding employment initiative in year two.

DELIVERABLES

- Establish a diverse Employment First Workgroup comprised of self advocates, families, providers and key state agencies ***July 2011***
- Establish a definition for integrated employment and identify metrics to collect baseline and ongoing data ***September 2011***
- Collect baseline employment data from the 93 enrolled supported employment providers ***September 2011***
- Identify and conduct orientation and training with 30 provider agencies to launch the Employment First Initiative ***September 2011***
- Identify 30 individuals for supported employment ***September 2011***

- Conduct nine regional job fairs in collaboration with advocacy and provider organizations and Louisiana Rehabilitation Services *October 2011*
- Host forums in each of the five regions and five Human Services Districts *November 2011*
- Meet goal of having 20 individuals with secured employment *December 2011*
- Identify an additional 75 individuals for supported employment *December 2011*
- Meet goal that 27 additional individuals have secured employment *March 2012*
- Meet goal that 28 additional individuals have secured employment *June 2012*
- Preliminary draft changes to OCDD policies and procedures to support Employment First *June 2012*
- Plan for implementation and expansion, including second year pilots, completed and submitted *June 2012*

Sustainable Home- and Community-Based Supports and Services

Background

The Department is focused on continued implementation and ongoing refinement of a structured resource allocation model toward a delivery system that is person-driven, cost effective and sustainable. The resource allocation model establishes a balance that recognizes fiscal savings, supporting the sustainability of community-based programs; acknowledges the uniqueness of each recipient and the challenges of developing a model that can work for everyone; and allows for flexibility when appropriate with a systemic review process and quality monitoring system.

Louisiana implemented its first comprehensive home- and community-based services (HCBS) waiver program for individuals with developmental disabilities in 1992 and amended the program significantly to create the New Opportunities Wavier (NOW) program in 2003. The waiver program had, and continues to have, one of the most comprehensive service menus in the nation and calls for one-on-one support services to foster individualized supports. The reimbursement practices were not based on the individuals support needs, and plans were written without using an assessment tool to assist in the allocation of resources. Additionally, two or three people could not share support services, with the exception of congregate vocational services, resulting in higher per person costs. DHH's Office for Citizens with Developmental Disabilities (OCDD) obtained Centers for Medicaid and Medicare Services (CMS) approval to amend the NOW program in July 2009 to include self direction to provide participants with the opportunity for greater control over their services and a greater emphasis on shared supports to build relationships while reducing one-on-one support services.

Implementation of a resource allocation system was mandated by the Louisiana Legislature in 2008 through House Resolution 190 and Senate Resolution 180, through House Concurrent Resolution 142 of the 2009 Regular Session, and again in 2010 when Act 305 was signed into law. Even before these mandates, DHH recognized that a system that matches need and resources is necessary for the sustainability of the home- and community-based service programs. In 2005, a number of performance indicators demonstrated that Louisiana's developmental disabilities services system was in need of modification, including:

- Over-reliance on one-on-one supports in community-based settings;
- Inequity within the services system: No connection to needs-based resource allocation approach;
- High cost of services per person: Approximately one out of four NOW service plans included annual prior-authorized costs in excess of $100,000;
- Overall fiscal effort ranking 4th in the nation: Total spending of $763.4 million; and
- More than 10,000 people waiting for community-based services with approximately 4,500 individuals receiving home- and community-based waiver services.

Beginning in 2005, OCDD worked closely with stakeholders to develop a resource allocation system that merged with its overarching person-centered planning principles and practices. The state worked to develop a data-driven methodology consistent with national best practices as a guide to fair and

equitable allocation of resources based on individual needs. By embedding the resource allocation system within DHH's person-driven guidelines for support planning process, OCDD is maintaining a responsive, flexible system that allows for unique individual planning and support differences.

OCDD began implementation of resource allocation in the NOW in October 2009. Since then, OCDD has managed to reduce the average cost per waiver participant by $12,000. This resulted in a plan savings of $6 million in FY 2010 and a projected cumulative savings of more than $44 million by the end of FY 2012. The success of this initiative is evidenced by OCDD's ability to expand participation in the NOW program by 8.3 percent with only a .48 percent expenditure growth in FY 2011. The program's expansion through efficiencies has reduced the wait time for services by four years. Today, the NOW serves approximately 7,500 individuals with developmental disabilities.

Goals

OCDD will increase self direction and consistency in planning supports and services in the NOW program with three precise objectives:

1. By the end of FY 2012, 238 additional people participating in HCBS waivers will use self direction;
2. OCDD will establish a baseline of shared and natural supports in the NOW to identify percentage increase for FY 2013; and
3. OCDD will resolve all pending cases requesting exceptions to resource allocation by June 30, 2012.

Program Strategy and Operations

The key to sustainability is not simply cost control, but also providing more effective and efficient supports and opportunities. OCDD's approach is to support control of services by the person and increase the ability of the system to move beyond simply identifying and providing paid supports through the following strategies.

1. Expand and refine self direction in waiver services;
2. Use expert assistance to increase the capacity of service coordination and waiver providers to identify and develop natural supports, community inclusion and generic services instead of just paid supports;
3. Use in-state advocacy organizations to provide more training and assistance to families;
4. Support individuals with developmental disabilities and their families through policy development and training that meets their needs through a better balance of paid and natural supports; and
5. Develop and implement more objective criteria for exceptions to resource allocation. The initial criteria have been developed and implemented; effectiveness will be assessed through FY 2012 and criteria will be refined as needed.

DELIVERABLES

- Implement Workgroup focused on family members as paid caregivers to conduct policy analysis and review ***September 2011***
- Complete 10 statewide NOW HCBS waivers self-direction training and informational meetings to all regions, districts and authorities; support coordination agencies, families-helping-families agencies and HCBS waivers recipients/families ***September 2011***
- Complete plan development for capacity-building project, including selecting two initial community provider organizations and one supports and services center ***September 2011***
- Develop and conduct surveys for current NOW and Children's Choice waiver participants to identify and target individuals and families interested in transferring to self direction ***September 2011***
- Begin implementation of self direction expansion for initial 20-person target group ***September 2011***
- Implement kick off plan with three participating organizations ***October 2011***
- Meet goal of 20 NOW participants using the self-direction option ***October 2011***
- Develop a registry list for HCBS waiver participants requesting the self-direction option ***November 2011***

- Meet goal of 40 additional NOW and/or ROW participants using the self-direction option ***December 2011***
- Complete 10 statewide ROW HCBS waiver self-direction training and informational meetings to all regions, districts and authorities, support coordination agencies, families-helping-families agencies & HCBS waivers recipients and families ***December 2011***
- Meet goal of 88 additional NOW and/or ROW participants using the self-direction option ***March 2012***
- Meet goal of 90 additional NOW and/or ROW participants using the self-direction option ***June 2012***
- Develop and complete 18 training opportunities and educational materials for 400 individuals, including individuals with developmental disabilities, their families and direct support staff ***June 2012***
- Complete determination on all requests for exceptions to resource allocation under consideration ***June 2012***
- Assess year one, plan for continued assistance to original pilot organizations in year two and expansion of infrastructure and the number of participating organizations ***June 2012***

Systems Rebalancing for People with Developmental Disabilities

Background

Nationally, the predominant residential service setting for people with developmental disabilities has shifted from large facilities to community-based living options. Additionally, Louisiana has a disproportionately high number of large and small institutional facilities (Intermediate Care Facilities for People with Developmental Disabilities – ICFs/DD) that are publicly or privately owned and/or operated. Louisiana also lags far behind the rest of the nation in terms of promoting community-based supports and services as an alternative. As a result, Louisiana's costs for developmental disabilities services tend to be higher than most states.

In 2004, Louisiana was one of only 12 states that had not closed a public ICF/DD and began the process of redesigning its long-term care system to one that offered choice, managed costs and raised the bar on quality. Today, Louisiana has closed all but three of its public ICFs/DD and has developed strategies to assist people in transitioning into the community. In 2004, there were 1,615 individuals residing in the state's nine institutions; today, approximately 840 individuals live in the remaining three state-operated institutions. However, challenges still remain.

According to *State of the States in Developmental Disabilities: 2011* (Braddock et al., University of Colorado, 2009 data), Louisiana ranks as the sixth highest state in the nation in terms of overall spending for individuals with developmental disabilities. Louisiana spends $7.13 per $1,000 of personal income compared with the national average of $4.34. Louisiana expenditures for institutions are the third highest in the nation – spending $1.61 per $1,000 of personal income on institutionalization services compared to the national average of $0.68.

The United Cerebral Palsy recently issued its 2011 report, Case for Inclusion, An Analysis of *Medicaid for Americans with Intellectual and Developmental Disability* (Lakin, et al., University of Minnesota 2009 data), which indicates a need for increased community-based services for people with developmental disabilities in Louisiana. Although Louisiana has made improvement, the state still lags behind the nation. Currently, only 60 percent of Louisiana's residents with developmental disabilities receive home- and community-based waiver services (HCBS) compared to the national average of 86 percent. Louisiana's home- and community-based services spending is more than 20 percentage points lower than the national average of 66 percent. The case for movement towards sustainable community living options is also supported by the national "Olmstead" mandate and Louisiana class action suits, such as Chisholm and the Department of Justice's settlement with DHH over its large public institutions. Louisiana is closely monitoring Department of Justice suits and settlements and other states, including a recent ruling in Georgia that mandates closure of all state-run ICFs/DD by 2015. Court mandated settlement agreements often undermine the ability of states to rebalance

the system in a manner that is flexible and makes sense for the individuals supported through the delivery system.

Goal

OCDD's long-term goal is to rebalance the intellectual and developmental disabilities service system over five years by:

1. Increasing the number of individuals with developmental disabilities receiving supports through HCBS waivers to the national average of 86 percent. In FY 2012, OCDD will increase the number of individuals served in HCBS waivers from 10,352 to 11,659; and
2. Increasing the percentage of resources directed to HCBS from 45 percent to the national average of 66 percent. In FY 2012, HCBS spending share will increase to 51 percent.

Program Strategy and Operations

Throughout FY 2012, Louisiana will continue its efforts to downsize its public ICFs/DD. OCDD has assessed all residents of these facilities using the Supports Intensity Scale/Louisiana Plus (SIS/LAPlus) needs-based assessment instruments. As a result of these assessments, OCDD is systemically offering community waiver opportunities to groups of residents progressing from those assessed with the lowest overall needs and supports to assist with activities of daily living; those requiring higher levels; and some with minor medical needs and/or challenging behaviors. OCDD will offer a choice of transitioning into community living using the New Opportunities Waiver (NOW) to all of its public ICFs/DD residents.

In addition, in FY 2012 OCDD will continue implementation of its new Residential Options Waiver (ROW). The ROW allows the funding to follow the person instead of being tied to the provider and offers new, innovative residential models and additional waiver services, long requested by stakeholders (i.e., occupational therapy, physical therapy, speech therapy and dental services). This waiver was designed to be a flexible, cost effective alternative to the NOW, and will aid efforts to rebalance Louisiana's developmental disabilities system through specific target groups by converting private ICFs/DD into shared living waiver homes. This will provide community alternatives to individuals in crisis whose only choice is institutionalization.

OCDD's rebalancing solutions advance the goal of systems rebalancing by:

1. Developing a plan of action to increase internal capacity and external community partner support to move the person-centered system approach to a larger scale;
2. Using expert consultation to support closure/downsizing efforts to bridge remaining knowledge gaps; improve practice; and enhance application of person-centered principles that produce positive outcomes for people transitioning from institutions;
3. Providing more flexible and specialized community-based service alternates to institutionalization; and
4. Converting private ICF/DD community homes into community-based waiver opportunities, assuring that community funding levels cannot exceed institutional ones and matching services to individual needs through nationally recognized assessment tools.

DELIVERABLES

- Complete plan development for capacity-building project, including selection of initial organizations ***September 2011***
- Begin plan implementation with participating organizations and identified internal and external staff ***October 2011***
- Train and support trainees and organizations during implementation ***October 2011***
- Assess phase one and plan for second year implementation and expansion ***December 2011***
- Identify referral sources and geographic area of requests for institutionalization due to behavioral issues ***September 2011***
- Form stakeholder workgroup to assess causes and options ***October 2011***
- Complete scope of problem assessment ***December 2011***

- Complete and submit proposed action plan to address community support and diversion for people with behavioral issues currently referred for institutionalization ***February 2012***
- Recruit and certify at least one host home per region as a residential alternative to institutionalization for children ***January 2012***
- Establish stakeholder workgroup to address ICF/DD conversion including reasons for underuse of the ROW, incentives to convert and changes needed to promote conversion ***September 2011***
- Release proposed workgroup recommendations and plans for increasing conversion of ICF/DD services to community supports ***January 2012***

Strengthening the Home- and Community-Based Infrastructure

Background

Over the past decade, Louisiana has experienced a significant increase in the number of residents in need of long-term care receiving services in home- and community-based programs rather than institutional settings. The shift to the delivery of home- and community-based services began in the 1960s, well before the passage of the Americans with Disabilities Act (ADA) in 1990. Title II regulation of the ADA requires public entities to provide services in the most integrated setting appropriate to the needs of the individual with a disability. Nine years later, the U.S. Supreme Court found that unnecessary institutionalization could be a form of discrimination under the ADA.

In 2005, DHH published *Louisiana's Plan for Immediate Action: Long-Term Care Choices for the Elderly and People with Disabilities*, which included integral input and feedback from a diverse group of statewide stakeholders. Louisiana then embarked on fundamental changes to the delivery system that would be effective in controlling costs of long-term care while ensuring quality services responsive to individuals' needs and preferences. The state has long recognized the system needed to be rebalanced based on the demands for home- and community-based service from the elderly, adults with disabilities and individuals with intellectual and developmental disabilities and their families. Additionally, regardless of where services were delivered, the fiscal impact and the anticipated growth in long-term care needed to be addressed to reduce service duplication, manage costs, simplify access and reduce the administrative burden for providers.

Over the last several years, DHH has worked to address the goals and objectives outlined in *Louisiana's Plan for Immediate Action*, including 12 areas of focus, such as quality management and licensing. In 2007, DHH published *Louisiana's Plan for Choice in Long-Term Care: Comprehensive Long-Term Care Reform Plan* that outlined progress toward the goals of the 2005 plan. The plan called for the development and implementation of a quality management system consistent with the state's transformation of its long-term service system for adults with disabilities, elders and individuals with developmental disabilities. DHH launched its quality management system in 2008 with ongoing analysis to refine strategies and procedures. The plan's action steps also included the consolidation of licensing for all Medicaid-reimbursed long-term care services into one licensing rule. The various programs had conflicting regulations that made operating and monitoring home- and community-based services (HCBS) cumbersome and difficult for providers to comply. A workgroup was convened and has worked for the past few years to create a multi-service licensing rule that would streamline regulations, assure compliance with federal and state statutory requirements and support the vision, values and guiding principles for Louisiana's long-term care services system. An emergency rule was published in the June 2011 *Louisiana Registry* and the public hearing was held on July 27, 2011. DHH is reviewing public comments and reconvene the workgroup to finalize the licensing rule.

As home- and community-based services and programs have grown, the system has become more complex with administrative burdens that are often focused on process compliance rather than outcomes. Additionally, program growth has outpaced updates to the infrastructure, such as programmatic polices that are conflicting or outdated as well as antiquated technology. This

has hampered the ability to assist good providers in meeting licensing regulations and performance standards. Conversely, the system has experienced increasing challenges associated with mitigating fraud, waste and abuse.

Recent improvements have focused on programmatic issues associated with cost effectiveness. Those efforts have been successful in many areas and have significantly lowered per person spending resulting in the expansion of people served with minimal increases in overall spending on home and community based services. For example, the New Opportunities Wavier (NOW) program grew by 8.3 percent last year with a spending increase of less than a half percent.

Finally, the recent downturn in the economy has heightened DHH's awareness and its stakeholders to the fact that everyone must work smarter to maximize limited resources and enforce accountability. Discussions with providers have identified areas that must be addressed to make necessary improvements; this warrants a comprehensive review of infrastructure issues, identification of solutions leading to plan development and implementation. Act 299 of the 2011 Louisiana Legislative Session builds on discussions that the Department and stakeholders have had to strengthen the home- and community-based infrastructure.

Goal

Over the next three years, the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities will improve capacity, quality and accountability of home- and community-based service infrastructure to preserve the service delivery system. By January 1, 2012, DHH will develop a comprehensive plan to do so as outlined in Act 299 of the 2011 Regular Session of the Louisiana Legislative Session.

Program Strategy and Operations

Over the course of FY 2012, DHH will engage a diverse group of internal and external stakeholders to provide input and feedback on systemic issues and solutions. This will involve working across departmental offices that administer, fund, operate and/or regulate HCBS. The final comprehensive plan to strengthen the home- and community-based infrastructure is expected to propose changes in rules, policies and standards for performance to make systemic changes to improve the delivery system's quality and accountability.

DELIVERABLES

- Develop and convene a steering committee comprised of internal and external stakeholders to develop a comprehensive plan ***August 2011***
- Develop and convene sub-committees comprised of stakeholders to address plan components outlined in Act 299 ***September 2011***
- Identify issues and solutions based on sub-committee input, projects plans and steering committee feedback ***October 2011***
- Collaborate across DHH program offices and bureaus that administer, fund, operate and/or regulate HCBS through monthly meetings ***August 2011-June 2012***
- Develop a comprehensive plan as outlined in Act 299 including any additional issues and solutions identified by the steering committee and/or sub-committees ***January 2012***
- Submit report to the House and Senate Committees on Health and Welfare ***January 2012***
- Finalize HCBS licensing rule ***January 2012***
- Repeal conflicting rules and regulations ***January 2012***
- Finalize implementation of all phases of comprehensive plan ***June 2012***

Managing Smarter for Better Performance

Louisiana Electronic Event Registration System (LEERS)

Background

LEERS is a multi-year endeavor to re-engineer the issuance and registration processes of Louisiana Vital Records. This new electronic web-based system replaces the inefficient and outdated DOS-based system that relies on paper vital event records. LEERS will streamline the registration of vital event records while improving data quality and the timeliness that vital event data is collected and accessible.

The LEERS Birth Module went live in December 2010 and the Sales and Management (SAM) Module went live in January 2011. Since implementing these modules, the following improvements have been realized:

- Reduction in the amount of time between birth and registration from an average of 72 days to 17 days;
- Reduction in the amount of time between birth registration and mailing of the complimentary birth certificate from 60 days to less than 3 days; and
- Improved data quality through use of built-in validations that ensure mandatory fields are complete and that data beyond normal ranges is verified by the user.

Louisiana e-Certs (LEC) is a web-based customer service interface for LEERS. This system will further streamline access to vital event records and improve customer service by allowing the public to request certified copies of vital event records online directly from Vital Records.

Goals

LEERS will provide vital records information to the citizens and other stakeholders timely, efficiently and accurately. Goals for FY 2012 include:

- Complete the annual software upgrade in July 2011;
- Implement the five remaining LEERS Vital Event modules by the end of FY 2012 to provide all data more timely and improve data quality; and
- Complete the business plan to initiate Louisiana e-Certs (LEC) by the end of FY 2012.

Program Strategy and Operations

Five additional LEERS vital event modules will be implemented in FY 2012. These modules include induced termination of pregnancy (ITOP), divorce, marriage, death and fetal death. Implementation of these modules requires thorough testing by Vital Records staff and external users, as well as continuous support from field representatives. To create awareness and promote the benefits of the new LEERS modules, Vital Records staff will conduct trainings with physicians and vital record professionals (e.g. funeral home directors, clerks of court, hospitals, etc.) throughout the state before, during and after initial implementation.

The following strategies will support the goal of providing access to vital records information in a timely, efficient and accurate manner.

LEERS Annual Software Upgrade: The upgrade for the birth module and SAM modules will provide internal and external users with several enhancements to improve efficiency and allow for increased productivity. The update will also address issues that have been reported from end-users.

Induced Termination of Pregnancy (ITOP), Divorce, Fetal Death and Marriage Modules: The addition of these vital event modules will facilitate the reporting and registration of these events in Louisiana. Currently, each of these modules is manual and labor intensive. The implementation of these modules will allow for electronic registration of these vital event records, which will decrease the amount of time it takes for Vital Records to receive the data. In addition, the standard validations required within the modules will greatly improve the quality of data received and disseminated through data requests for research, public health and health policy purposes.

Death Module: The implementation of the LEERS death module will dramatically change the way death records are registered in Louisiana. The current death registration process is manual and involves the record being physically moved through various facilities. This process requires coordination between the family of the deceased, funeral home directors, the physician/coroner and the parish health units. This process currently takes 4 to 5 months from origination to registration. If there is a problem or mistake with the record, it must be returned to the parish health unit for the funeral home or physician/coroner to complete the record correctly, lengthening the process.

By using an electronic registration system, death records can be electronically signed and registered with Vital Records. We anticipate that implementation of the death module will

significantly shorten processing time; reduce errors; provide researchers and policy makers with richer data; and allow real-time data sharing so that public assistance can be stopped and voter registration rolls updated in a timely manner.

In addition, the LEERS death module will allow burial transit permits to be requested and issued through LEERS to a funeral home 24/7. A burial transit permit is needed before the remains of a deceased person can be buried, cremated or removed from the state. Currently, deputy local registrars in parish health units issue burial transit permits during office hours and some parish health units have contracts with special agents for issuance of burial transit permits after hours and on weekends.

Prior to implementing the LEERS death module, current baseline data will be collected on the length of time it takes to register a death record; the number of death records returned to funeral homes due to errors; and the length of time it takes to report the death to other agencies. The same data will be collected after the death module is implemented to evaluate the improvements gained by implementing LEERS.

Data Collection for Birth Outcomes Initiative: Changes are being planned to collect additional statistical data on Louisiana newborns with a gestation under 39 weeks. The goal of collecting this additional data is to better inform policy decisions aimed at improving Louisiana's poor birth outcomes.

Louisiana e-Certs (LEC): Currently, customers can order certificates online through a third-party intermediary that charges fees to customers. Louisiana e-Certs (LEC) is a web-based customer service interface for LEERS that will allow the public to request certified copies of vital events directly from Vital Records at a nominal cost (births, deaths, fetal deaths and Orleans Parish marriage records). This service will be integrated with the LEERS SAM module to streamline request processing and the issuance of certified copies. Business requirements will be drafted to solidify the expectations and resources necessary for this project by the end of FY 2012, and a business plan will be completed to move forward with this service.

DELIVERABLES

- Conduct LEERS annual software update ***July 2011***
- Implement ITOP Module ***August 2011***
- Implement Divorce Module ***September 2011***
- Implement Marriage Module ***November 2011***
- Implement Fetal Death Module ***June 2012***
- Collect baseline data on the current death registration process ***October 2011***
- Implement Death Module - 402 funeral homes will use the LEERS and all physicians will have the ability to use LEERS for registering deaths ***March 2012***
- Collect data on the death registration process after the LEERS Death Module implementation to evaluate process improvements ***June 2012***
- Complete birth certificate additions for Birth Outcomes Initiatives ***March 2012***
- Complete the Louisiana e-Certs (LEC) Business Plan preparations for development ***June 2012***

Louisiana's Disaster Data Collection System for Health Care Facilities- EMSTAT

Background

In 2008, Hurricanes Gustav and Ike highlighted the Department's need for additional visibility into the real-time status and operational capabilities of critical health care facilities during and after emergency events. In response, emergency rules were promulgated that required hospitals and nursing homes to report their status, but the existing systems did not have the capability to capture the data DHH required, and were ultimately unsuccessful. However, after the hurricanes of 2008, DHH's Emergency Preparedness Section led a major initiative to develop and deploy core systems designed to capture critical status information and to support critical operations, including a facility status reporting system. This working group developed the business requirements for such a system and evaluated the alternatives that could be implemented for the 2009 hurricane season.

After a detailed review of existing and potential resources, DHH moved forward with the adaptation and expansion of a current facility reporting

system housed within DHH's Health Standards Section application. This application was renamed EMSTAT and the initial version was deployed by June 1, 2009. The continued development and enhancement of EMSTAT is required to achieve a robust database that can serve as the information hub for a variety of other emergency management modules and systems throughout DHH.

As the first version of EMSTAT was a Medicaid (BHSF) application, the entire emergency management technology infrastructure has continued to be supported on the Medicaid domain. Those functions will be transferred to the main DHH IT technology infrastructure between the close of the 2011 hurricane season and the onset of the 2012 hurricane season.

Goal

EMSTAT's goal is to provide continuous access to the application by all licensed hospitals and nursing homes in the state. Strategic use of EMSTAT will help DHH avoid "siloed" databases by using the core EMSTAT database as the information hub for other key emergency management applications and reporting tools throughout DHH. Moreover, DHH will use EMSTAT as the primary automated reporting tool for the federal HAvBED system.

Program Strategy and Operations

Louisiana will continue to enhance EMSTAT, a web-based facility status reporting application that incorporates census reporting and bed availability features. EMSTAT currently incorporates tracking of facility generators and power status; overall operating, evacuation and fuel status; and detailed census data and facility contact information. This constellation of data gathered real-time during an event has allowed for the development of powerful simulation tools that can forecast critical facility needs during an event.

The operational concept for this year is to both continue to provide access to EMSTAT while planning for future infrastructure improvements. The major infrastructure change will be a move from the Medicaid technology infrastructure to the main DHH infrastructure. This will involve detailed planning for issues such as disaster recovery and data backup, server availability and troubleshooting. This move will occur between the 2011 and 2012 hurricane seasons.

DHH will expand the use of the core EMSTAT database to serve data to other applications, avoiding "siloed" databases and duplicate data entry. This includes deployment of other modules that will provide enhanced application security and user account management, messaging and incident management functions survey management functions, and resource monitoring functions. All will use the EMSTAT database as the core system for facility and contact information.

Finally, EMSTAT will be used as the feeder system to the federal HAvBED system through an XML-based integration. This will allow staff to discontinue the use of an expensive third-party system going forward, providing savings that can be used to support the emergency management information management function.

DELIVERABLES

- Migrate EMSTAT to DHH IT Infrastructure ***December 2011***
- Establish a regular database review process ***December 2011***
- Connect all emergency management modules to EMSTAT ***November 2011***
- Deploy a GIS tool connected to EMSTAT data ***November 2011***
- Deploy an XML transformation tool to link to federal systems ***November 2011***
- Conduct at least two successful data transfer tests with federal systems ***May 2012***

Combatting Fraud and Abuse

Background

The Department is committed to administering the Medicaid program with integrity and, as stewards of public dollars, will not tolerate fraudulent or abusive behavior. In calendar year 2010, Louisiana Medicaid had 11,362 providers who were paid $600 or more, and were therefore issued federal 1099 forms. Per data supplied by DHH's fiscal intermediary, there was a total of 98,963,399 claims submitted, resulting in total Medicaid payments of more than $5.5 billion over the same time frame. The majority

of these providers deliver high quality services and do not perpetrate fraud or abuse the system via overutilization and other wasteful practices. However, DHH has taken steps to enhance our ability to detect and root out the fraudulent and wasteful behavior that does occur and will continue to do so into FY 2012.

Louisiana Medicaid's program integrity function currently conducts review of Medicaid claims both on the front-end, before the claim is paid, as well as in post-payment review. Pre-pay functions include system edits that automatically detect variations in claims that signal fraudulent activity, hospital admission and length of stay review; and approval based on nationally recognized Interqual criteria, radiology utilization management (RUM); and other pre-certification and prior authorization functions. Unfortunately, too often staff is forced to play the "pay and chase" game by fraud detection and recoupment after the payment is made. These functions include some limited data-mining, investigating complaints through the fraud hotline and other investigations based on staff analysis of claim histories. Also, more than 10 percent of active providers are audited annually, resulting in a variety of actions ranging from education to exclusion from the Medicaid program. The current review structure also allows for a close working relationship with the Attorney General's Medicaid Fraud Control Unit, with whom case issues are discussed on a monthly basis. In FY 2011 alone, 20 percent of case closures resulted in a referral to the Medicaid Fraud Control Unit.

The below chart shows the amount of dollars identified and recovered through the current review structure for the past five state fiscal years. Since FY 2007, there has been a nearly 500 percent improvement in the amount of dollars recovered.

State Fiscal Year		Dollar Amounts	
Time From	Time To	Dollars Identified	Dollars Recovered
07/01/06	06/30/07	$1,429,648	$1,423,517
07/01/07	06/30/08	$2,082,062	$2,074,804
07/01/08	06/30/09	$6,240,578	$5,856,659
07/01/09	06/30/10	$5,632,691	$4,466,303
07/01/10	06/30/11	$8,793,220	$8,456,744

Goal

Through an aggressive realignment of it's fraud and abuse system, DHH hopes to significantly increase cost avoidance and recoveries. DHH seeks to achieve program savings through denial of improper claims prior to payment rather than identifying such claims after payment has been made.

This enhanced pre-payment review process will complement the current front-end claims processes DHH currently uses to reduce improper and will further assist in identifying areas that require strengthening of policy and additional system editing. Program Integrity has established a recovery goal of $12 million to be attained through the pre-payment (cost avoidance) and post-payment review structures for FY 2012.

Program Strategy and Operations

Program Integrity will implement a pre-payment review process through DHH's current contractors, where claims will be adjudicated and subsequently pended for further review prior to payment. As part of this process, Program Integrity will be using ClaimCheck to help determine which claims go into pend status. ClaimCheck is a versatile tool that can be modified to look for trends or patterns indicative of fraud and/or abuse.

As DHH's move forward with the implementation of this process, a gradual transition to a new payment schedule, will minimize the financial impact on the provider community. This will also align with the CCN prompt payment provisions.

DHH, pursuant to Affordable Care Act requirements, will release a Request for Proposals for one or more recovery audit contractors. Chosen recovery audit contractors will conduct data mining and post-payment review on a contingency fee basis. This should lead to increased recoveries based on fraud and abuse without an increase in cost to DHH. In addition to these recovery audit contractor's efforts, Program Integrity will continue to conduct its own post-payment review of suspicious claims activity.

DHH will aggressively audit and pursue collections from providers guilty of fraud and/or abuse. As a result of prior audits in the area

of home- and community-based services, DHH has sent notices of overpayments to numerous providers totaling approximately $4.2 million. Program Integrity will interface closely with DHH's legal staff to ensure maximum recoveries via collection suits and liens, if necessary.

DHH will also be implementing a project with Lexis Nexis, as part of the Department's efforts to improve the integrity of home- and community-based services. The project's purpose is to make systemic changes related to the findings of the audits conducted by the audit contractor. Lexis Nexis will screen all providers who render long-term care, personal care attendance and supervised independent living services and will provide a provider ranked batch analysis checked against numerous state and national databases that indicate potential risk of fraud.

DELIVERABLES

- Implementation of Prepayment Review Initiative ***December 2011***
- Lexis Nexis batch analysis completion ***December 2011***
- Recovery audit contractor implementation ***February 2012***
- Payment calendar transition completion ***July 2011-June 2012***

Eat Safe Louisiana

Background

There are approximately 34,000 retail food establishments in the state of Louisiana. DHH's Office of Public Health (OPH) sanitarians conduct a 300-point inspection for each of these establishments. In the past, inspection results have not been readily accessible to the public.

The inspection process is an evaluation of the requirements addressed in Title 51, Public Health Sanitary Code, Part XXIII and Retail Food Establishments. There are 17 categories on which a retail food establishment is evaluated. Violations in eight of these categories are considered critical and the remaining nine categories are considered non-critical violations. The eight critical violations include food condition, source and labeling; food time and temperature; employee health and practices; cross contamination; food contact equipment, utensil construction and sanitization; toxic chemicals; water and sewage; and insects, rodents and animals. The nine non-critical violations include labeling; food protection; utensils, equipment and single service; personnel, clothes and hair restraints; toilets and hand washing facilities; garbage and refuse disposal; structural, design, maintenance and plumbing; permits, plans and food safety certificates; and miscellaneous (linen, wiping cloths, maintenance equipment, laundry facilities and water pressure).

Sanitarians use an electronic inspection program to conduct inspections. The program provides a drop down selection button in each category that allows the sanitarian to immediately identify the specific applicable code reference and statement for each violation. The information can then be printed and provided to the retail food establishment at the time of the inspection.

Goals

Louisiana will see a reduction in the number of restaurant-attributable foodborne disease outbreaks through three measurable goals:

- Online availability of retail food establishment inspections that are completed each month within one week of the inspection;
- Reduction in the number of retail food establishment complaints from 1,653 (FY 2011) to 1,488 in FY 2012 (a 10 percent reduction); and
- Decrease in the number of retail food establishment re-inspections from 5,688 (FY 2011) to 5,119 in FY 2012 (a 10 percent reduction).

Program Strategy and Operations

The public has access to Louisiana retail food establishment inspections at www.eatsafe.la.gov. Links are provided on the current DHH website as well as the Retail Food Program site, and DHH is working with new and traditional local media to maximize public awareness.

Eat Safe Louisiana went live in August of 2011. When available, up to three of the most recent inspection reports for each establishment

are provided for public access. All retail food establishment inspections will be uploaded within seven days of the inspection being completed. In addition to inspection data, the site also contains information to educate the public on food safety (commercial and residential), emergency/disaster food and water safety and other useful information. The website also allows consumers to contact DHH to issue a complaint or comment about restaurant sanitary conditions.

An improvement in food safety and sanitary conditions in retail food establishments will be measured by a reduction in the number of food-related complaints DHH receives and the number of re-inspections required due to uncorrected violations. This will be measured and monitored on a quarterly basis. Increased transparency of retail food inspections is expected to decrease both of these measures progressively over a one-year period.

DELIVERABLES

- Website "Go Live" ***August 2011***
- Explore the utility and viability of mapping restaurant inspections results and making available for the public ***October 2011***
- Collect data on the number of complaints generated. A decrease from 1,653 to 1,488 (10 percent) is expected by the end of 4th quarter. ***June 2012***
- Collect data on the number of re-inspections required. A decrease from 5,688 to 5,119 (10 percent) is expected by the end of 4th quarter. ***June 2012***

DHH Information Technology

Background

The Department's myriad technology products and processes run everything from case management and compliance to security and training functions. Indeed, the current IT portfolio is comprised of 236 applications operating in a virtual server environment configured with 300 virtual servers supported by 225 physical units. A parallel environment of 185 virtual servers supported by 120 physical servers is also configured to support Medicaid. Almost all of the current inventory of applications and servers are designed to provide comparable functionality, yet constructed and operated independently for the department offices and bureaus. For example, the case management enterprise portfolio has 109 distinct applications providing functionality that is duplicated multiple times over. By today's IT standards and best practices, DHH's operations are inefficient and architecturally flawed when viewed from an enterprise-wide perspective.

Even more challenging are the inherent barriers faced by decision makers and providers which are institutionalized into the current architectures. If a more integrated IT architecture replaced what is in place today there would be a more cohesive data linkage that would facilitate a more thorough and comprehensive analysis of available data and a more structured and informed view of the actual impact on health outcomes.

A variety of factors have contributed over time to the creation of this duplicative, inefficient, and less-effective portfolio of systems. Variability, timing and regulations of available funding fostered a siloed approach that has led to the implementation of systems that meet narrow program objectives.

Historically, IT projects have followed federal and state funding streams with very little coordination across the Department which would leverage common technology assets and resources. Also, as new systems were proposed, no mechanism existed that would recommend cost effective alternatives that leveraged existing functionality to better share and integrate data while containing cost.

- Good business practices at all levels demand that funds be deployed to expand innovative technology solutions in the most cost effective manner by applying "best practices" in architectural and implementation design.
- It is also important to be pro-active at measuring the positive ROI return for each IT investment which would influence the decision making process to either build or not-build.

Fortunately, this transformational focus offers the Department a wide array of opportunities to develop new decision making criteria and streamline delivery processes, all of which are intended to achieve better outcomes.

Goals

Transition DHH technology architecture and service delivery to a consolidated enterprise-wide model in order to accomplish the following;

- elimination of duplicative systems, processes and organizations which are not currently operating in the most cohesive manner;
- improve the value proposition for all IT investments by ensuring there is always a positive ROI which exceeds an acceptable hurdle rate;
- position the foundational parts of service delivery such that the department can adopt changes which will result in new and better service offerings; and
- institutionalize a set of operational principles which will support sustainability of sound IT best practices.

Strategy

In July 2011, through the re-allocation of current positions, Secretary Greenstein appointed the Department's first-ever Chief Technology Officer (CTO) to work side-by-side with the Chief Information Officer (CIO) and other Department leadership to develop, plan and implement the Department's IT integration strategy and resource re-alignment.

The CIO and CTO will jointly develop a cohesive, department-wide IT strategy that will:

- Capitalize on current investments,
- Align future expenditures and resources for current transformations; and,
- Ready the Department for future changes in the state and national health care programs.

These initial activities will focus on discovery and gathering information to develop the strategy and the accompanying tactical plans. The areas of focus will be on five primary categories: People, Process, Financial, Information and Technology.

This initial effort is heavily dependent on collaboration across DHH offices and extra-departmental organizations including but not limited to the Department of Administration (DOA), Department of Child and Family Services (DCFS), and University of New Orleans (UNO).

DELIVERABLES

- Provide an analysis document of
  - as-is IT inventory and planned procurement,
  - as-is human resource organization and alignment, and
  - as-is and planned IT budgeting and expenditures ***August 2011***
- Identify and create a department-wide Information Technology Core Team (Steering Committee) to establish core IT Governance. ***October 2011***
- Collaborate with DHH CIO and Medicaid IT Director (via UNO) to build IT personnel resourcing strategy ***October 2011***
- Develop and complete future state architectural vision and associated document frameworks document with DHH CIO or other IT architect resource ***October 2011***
- Collaborate on DHH IT Strategic Plan and Year 1–3 tactical plans (People, Process, Financial, Information and Technology ***August 2011***
- Refine Draft DHH IT Strategy with Department leaders, including assistant secretaries, bureau and division directors ***September 2011***
- Finalize and submit DHH IT Strategic Plan. Complete working delivery/project plans for Year 1 tactical plan, including the funding, resource re-allocation and financial business case ***October 2011***
- Refine and obtain agreement, consensus and commitment on the DHH IT Strategic Plan and details of the Year 1 Transition/Tactical plan ***November 2011***
- Initiate Phase 1 of transition/tactical plans ***December 2011***
- Launch Technical and Financial Implementation Phase of DHH IT Strategy to focus on:
  - Technical Infrastructure Design
  - Foundational Architectural Platforms
  - Applications and Tools ***January 2012***

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