Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

June 24, 2009

The Honorable Willie Mount, Chair
Senate Health and Welfare Committee
P.O. Box 94183
Baton Rouge, LA 70804

Dear Senator Mount:

In response to Senate Resolution No. 180 (SR 180) of the 2008 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. The resolution urges and requests the Department of Health and Hospitals to develop and implement mechanisms to provide the most cost-effective means of financing for the Long-Term Personal Care Services program and the New Opportunities Waiver.

The Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services within DHH are available to discuss the enclosed report and recommendations with you and the members of the Senate Health and Welfare Committee. Please contact Kathy Kliebert, Assistant Secretary of the Office for Citizens with Developmental Disabilities, at (225) 342-0095 or Hugh Eley, Assistant Secretary for the Office of Aging and Adult Services, at (225) 219-0223 with any questions or comments you may have.

Sincerely,

Alan Levine
Secretary

Enclosure

SENATE RESOLUTION NO. 180

2008 REGULAR SESSION

COST CONTROL MECHANISMS

Report to the Senate Committee of Health and Welfare:

The Department of Health and Hospital would like to express its appreciation to the Louisiana Legislature for its willingness to address the development and implementation of cost control mechanisms for the Long Term Personal Care Services program and the New Opportunities Waiver.

CHARGE OF THE RESOLUTION

The Department of Health and Hospitals was charged with the following:

- To develop and implement cost control mechanisms for the Long Term Personal Care Services program and the New Opportunities Waiver.
- To provide interim progress reports as requested by the Senate Committee on Health and Welfare.
- To submit a written report and presentation to the Senate Committee on Health and Welfare at least forty-five days prior to the convening of the 2009 Regular Session.

The resolution noted that while it is in best interest of the state to operate a cost-effective and high-quality home and community-based services program for citizens who are elderly or have developmental disabilities, the high cost of the Long Term Personal Care Services program and the New Opportunities Waiver pose the greatest risk to the financial stability of the state's long-term care services. Without restructuring of these programs, the sustainability of long-term care and home and community-based services is threatened and the ability of the state to meet the growing needs of these citizens is impaired.

This report is prepared in two sections: Part A - New Opportunities Waiver services and Part B - Long Term Personal Care Services program. Part A was prepared by the Office for Citizens with Developmental Disabilities and Part B by the Office of Aging and Adult Services. Presentations to the Senate Committee on Health and Welfare will be made respectively by the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services.

PART A – NEW OPPORTUNITIES WAIVER SERVICES

It should be noted that during the 2005 Regular Session of the Louisiana Legislature, House Concurrent Resolution No. 87 charged the Department of Health and Hospitals with studying cost control mechanisms for the New Opportunities Waiver (NOW) to ensure cost-effective administration and service delivery. The Office for Citizens with Developmental Disabilities assumed operation of the NOW program in November of 2005. Since that date following the charge of HCR No. 87, the Office has worked diligently to address the high costs associated with the NOW.

This section of the report will describe the efforts of the Office for Citizens with Developmental Disabilities to address the charge of the resolution related to the New Opportunities Waiver.

CHRONOLOGY

Prior to the adoption of SR No. 180, the Office for Citizens with Developmental Disabilities (OCDD) had initiated efforts to develop and implement cost-control mechanisms to address the high costs of the New Opportunities Waiver (NOW) as part of the state's Comprehensive Long Term Care Plan. The goal of all actions taken by the Office has been a fair and cost-effective waiver. Stakeholders, including self-advocates, families, providers, and advocates, have been involved throughout this process. The following information provides a chronology of OCDD's actions related to converting the NOW to a cost-effective waiver.

Initial efforts include the development and adoption of a needs-based assessment. A review of assessment instruments used by other states was conducted, and the American Association on Intellectual and Developmental Disabilities (AAIDD) Supports Intensity Scale (SIS) was the unanimous choice of OCDD and stakeholders. Following a sample administration of the assessment, it was determined that a supplemental tool was needed to address specialized support needs of individuals not included in the SIS. The Office then, in collaboration with AAIDD, developed and validated the Louisiana Plus (LA Plus) to accompany the SIS. [Note: To date over 4,200 SIS/LA Plus assessments have been completed, along with an additional 300 assessments for planning purposes for new waiver recipients (2,025 new slots)].

With the involvement of stakeholders, OCDD then began its review and consideration of approaches to control waiver costs. A Stakeholder Meeting was held in November 2007, and participants were given an overview of current challenges to the NOW, solutions in process, typical approaches to waiver cost control, short and long term strategies for cost effective utilization management in home and community-based services, long-term strategies, and anticipated outcomes of strategies. The workgroup and OCDD staff carefully considered some of the typical approaches which have been taken by other states to stabilize the growth of waiver costs. The study "A Comparative Study of the Cost Controls used in Florida and Selected States to Manage the Medicaid Home and Community Based Services for People with Developmental Disabilities" (March 2008

Kingsley Ross, Robert Gettings, and Cynthia Holmes) was utilized in this analysis. The following approaches were considered:

- Client Enrollment Limits
- Case Management
- Needs Assessment
- Prior Service Authorization
- Service Request Authorization
- Caps On Total Expenditures
- Service Limits
- Provider Reimbursement Limits

Another tool which states have the authority to utilize involves a determination of whether services, and the vendors providing them, effectively meet the needs of the consumers. This process is often called utilization review and affords states the opportunity to determine whether there may be more effective ways of meeting participant needs.

Louisiana had employed three of the eight typical approaches: Client Enrollment Limits, Prior Service Authorization, and Provider Reimbursement Limits. The remaining tools were not being used or not fully used. Case Management services were being contracted to coordinate and monitor service delivery but not used to limit costs. Additionally, the Office was in the process of transitioning to a Needs Assessment (SIS/LA Plus) and used some Service Provision Limits. However, systematic utilization review was not yet employed.

In January 2008, the Office had the Human Services Research Institute (HSRI) study and prepare a brief entitled "Discussion of Key Resource Allocation Policy Issues in Louisiana" in order to provide the group with additional information to aid in making policy decisions. Later that month, a second Resource Allocation Stakeholder Meeting was held, and one of the consultants from HSRI presented the information to the stakeholders. The group began its initial efforts toward consensus of identification and resolution of policy issues related to resource allocation. Four subgroups were developed to address the most immediate policy issues: Prioritization of the Registry, Outcomes Measurement, Fairness across Settings, and New vs. Existing (services). (Note: These subgroups met between February and November of 2008 and provided recommendations on resource allocation related to each policy issue.)

OCDD then began collaboration with national experts on resource allocation formulas to design a level of needs system based on the SIS/LA Plus, which would afford a validated methodology for determining support needs of individuals and a proposed methodology for funding. The Office also initiated work with stakeholders on the development of policies and procedures which would allow the state to use the SIS/LA Plus to allocate appropriate waiver opportunities based on an identified acuity level. As this work was in progress, the Office began the development of a new comprehensive waiver (Residential Options Waiver) which would provide 24-hour home and community-based supports in a

cost-effective manner through the use of shared supports and individual caps based on acuity levels. [It is anticipated that this waiver will be approved by the Centers for Medicare and Medicaid Services (CMS) and implemented in 2009.]

In collaboration with national consultants and stakeholder groups, OCDD developed a new Individual Support Plan (ISP) process and format for people receiving services and supports. The plan is developed following identification of support needs through the SIS/LA Plus and other discovery activities. An electronic version of the ISP is being developed, which will be automatically linked to the SIS/LA Plus database and will allow for generation of support planning which stages in level and types of supports.

On 6/02/08, a Resource Allocation Stakeholder meeting was held. Presentations included: Status of LA Resource Allocation Model, Subgroup Recommendations, and Discussion and Consensus on Policy Recommendations. OCDD continued to make all efforts to provide information related to the resource allocation project and to solicit input from stakeholders.

On 6/23/08, Senate Resolution No. 180 and House Resolution 190 were adopted.

In August 2008, an analysis of the use and cost of all service for NOW participants for fiscal year 2006 and fiscal year 2007 was prepared by Burns & Associates, Inc.

At the 8/29/08 Resource Allocation Stakeholder Meeting, stakeholder decisions/ recommendations to guide the process of developing a resource allocation model were reviewed. These recommendations included:

- The resource allocation model should be implemented across all settings.
- The model was proposed to be implemented with the new service recipients (this year) and later applied to those currently receiving ICF/DD and waiver services (next year).
- Individual outcome evaluations, as well as system evaluations, will be critical to the process.
- Funds will be designated (set aside) for emergency waiver opportunities to avoid individuals in emergency situations being placed on a waiting list.

Additionally principles of needs assessment relative to resource allocation, recommended by the group, included:

- People should get the supports they need.
- There are benefits to have a unified way to measure support needs.
- Resources should be allocated fairly.

The process of developing Louisiana's resource allocation model continued with the development of a system of levels of support need based on the SIS/LA Plus assessments.

The level of need in the person-centered planning process would then determine the initial allocation of Individual and Family (IFS) Support hours that a person would receive.

The Louisiana Seven Level System includes the following levels:

- Level 6 - Persons with the most Extensive Behavior Support Needs
- Level 5 - Persons with the most Extensive Medial Needs
- Level 4 - A specialty group including people who have moderate to extensive Behavior Support needs and low to moderate General Support Needs
- Level 3 - People at the 76th percentile or greater with regard to their General Support needs and who have low to extensive Behavior Support Needs
- Level 2 - People who fall from the 51st to the 75th percentile or less with regard to their General Support needs and who have moderate Behavior Support Needs
- Level 1B - People who fall between the 25th to 50th percentile with regard to their General Support needs and who have low Behavior Support Needs
- Level 1A - People who fall below the 25th percentile indicating less General Support needs than 75% of the population with developmental disabilities.

The Louisiana Level System was developed by an analysis of a representative sample of all service recipients placed in their appropriate level based on assessment results and validated by an in-depth review of over 100 comprehensive plans of care of individuals to assure that the proposed allocation of IFS hours would serve the needs of the majority of participants at each level. The model for allocation of IFS hours, including modifications based on stakeholder feedback, was presented and accepted at the 10/17/08 Resource Allocation Stakeholder Meeting.

In November 2008, a meeting was scheduled to review SR 180 and HR 190 with family members and to ask for further suggestions related to the Office's response to the charge of the resolution. On 12/15/08, a meeting was scheduled specifically for self-advocates to obtain additional self-advocate participation and input on OCDD's resource allocation model and cost control mechanisms. These meetings and other informational/training meeting were held during this project to ensure that stakeholders understand the new system and have confidence in how it has been constructed.

Through the efforts of OCDD staff and stakeholders, the "OCDD Guidelines for Planning Model for the New Opportunities Waiver" process has been developed as a cost control mechanism to address the high cost of the NOW. This process, which begins with an individual needs assessment (SIS/LA Plus) and discovery, results in the allocation of initial Individual and Family Support (IFS) hours based on the assessment of individual support needs. This allocation takes into consideration whether a person lives with family or independently and the age of the person. (Through a supplemental request and review process, individuals may access additional IFS hours based on demonstrated need.)

The "Guidelines for Planning Model for the New Opportunities Waiver" is based on the following planning assumptions:

- People will have a full life with an array of activities and interests.
- People will have meaningful work, school, or other appropriate daytime activities.
- People will use a variety of supports (natural, community, educational, etc.).
- People living independently with 24-hour support will be allocated shared support hours unless these are reasons a person must live alone.
- Plans of care will foster greater independence for each person.
- People who live with family have different paid support needs than those who live independently and therefore their needs will be considered separately.
- Natural/community supports are to be used as appropriate and applicable in each person's living circumstances.

ANTICIPATED OUTCOMES

The Office for Citizens with Developmental Disabilities and the Resource Allocation Stakeholder group believe that implementation of the "OCDD Guidelines for Planning Model for the New Opportunities Waiver" will result in the following:

- Reduction of the time that people wait for services
- Increase in the number of people served with current resources
- Stabilization of waiver costs
- Increase in the outcomes for people supported through the waiver
- Conversion to a more cost-effective waiver (Current average = $70,000 to projected Resource Allocation Model Upper Limit Average of $49,335. This average cost is projected to be achieved at the end of a three-year phase in plan.)

CURRENT STATUS

OCDD has presented the plan for implementation of the "OCDD Guidelines for Planning Model for the New Opportunities Waiver" to the Joint Legislative Committee on the Budget, and it has been approved by the committee.

Medicaid has discussed implementation of the "OCDD Resource Allocation Model for the New Opportunities Waiver" with Centers for Medicare & Medicaid Services (CMS). Medicaid after consultation with CMS has approved OCDD's request to grant a six-month extension for current plans. However, the request for utilization of the Resource Allocation Model for all new waiver applicants and a three-year phase of the model for current recipients has not yet been approved.

PART B – LONG TERM PERSONAL CARE SERVICES PROGRAM

CHRONOLOGY

Prior to the adoption of SR No. 180, and as part of the State's Comprehensive Long Term Care Plan, the Office of Aging and Adult Services (OAAS) had already initiated efforts to develop and implement cost-control mechanisms to address the relatively high costs of the Elderly and Disabled Adult Waiver (EDA). Though the average cost and total expenditure of OAAS waiver programs, including the EDA waiver, is much less than the average cost of the OCDD waivers, they have a larger problem regarding cost effectiveness. This is because the federal cost effectiveness standard OAAS waivers must meet is lower, because the cost is compared to nursing home costs rather than to higher ICF/DD costs.

The goal of all actions taken by the Office has been to develop community-based programs that allocate available resources fairly and that provide cost-effective options for recipients. OAAS initial efforts include the development and implementation of new waiver options, such as the proposed Adult Residential Care waiver; the inclusion of more cost-effective services such as adult day health care in the EDA waiver; and the implementation of shared supports, consumer-directed services and other service delivery options that are more cost-effective. Stakeholders have been involved in all these efforts.

Also consistent with the Comprehensive Long Term Care Plan, OAAS had begun working on a new resource allocation method that would allocate a set number of hours based upon assessment results. Service planners would identify tasks (such as assistance with bathing, meal preparation, etc.) to be performed within that allocation of hours, rather than adding up a fixed number of minutes per task to get the total number of hours as is currently done. This new method would provide more flexibility in service delivery within the approved number of hours, simplify documentation requirements, and link service allocation more closely to the assessment.

The new method was originally designed to allocate hours in a way that would be cost neutral. However, OAAS learned in the fall of 2007 that the EDA waiver was out of compliance with Centers for Medicare & Medicaid Services (CMS) cost-effectiveness guidelines. This prompted OAAS to consider how the new method might also be used to more effectively and equitably control costs.

It is important to recognize that the primary reason for waiver non-compliance, and the cause of the relatively high average cost of EDA waiver slots, is the LTPCS program. The Long Term Personal Care Services (LTPCS) Program was implemented in 2004 in accordance with the settlement agreement in the Barthelemy class action lawsuit. It has grown from a $30 million program in FY 2005 to an almost $200 million program in FY 2008, with program growth driven primarily by large increases in the numbers of participants rather than by dramatic increases in the amount of service received. When LTPCS became available, personal care service was removed from the EDA waiver,

consistent with CMS policy that state plan services are utilized when available. This had the effect of removing personal care from the daily cap on EDA services (currently $73.34). As a result, use of LTPCS by EDA recipients, combined with use of high amounts of the waiver companion service, caused the EDA waiver to exceed the cost-effectiveness limits.

Upon learning of the cost-effectiveness problem, OAAS began to develop a plan to use the new resource allocation system to apply fair, acuity-based reductions in hours and costs in order to achieve cost-effectiveness. Fortunately, the new allocation system provides a mechanism for implementing incremental reductions in the number of hours allowed, without cutting significant numbers of hours from high-need recipients.

All OAAS programs use an assessment tool known as the Minimum Data Set for Home Care (MDS-HC), and this assessment is the basis for the new resource allocation system. The MDS-HC is part of a suite of tools developed by a consortium of researchers and used internationally to assess levels of care and develop case-mix resource allocation systems. These tools allow recipients to be assigned, based on their individual assessments, to what are know as Resource Utilization Groups (RUGs). For instance, one of these systems, RUG-III, is used by Medicare in nursing homes nation-wide, as well as by Louisiana's Medicaid program, for calculating nursing facility payment rates. The RUG-III Home Care (RUG-III/HC) is intended for use in home and community-based settings and has been shown to explain significant variation in resource utilization. RUG-III/HC is used for the new OAAS resource allocation system.

Working with consultants, OAAS conducted research on the current approval and utilization of services for LTPCS and EDA waiver. The goal of this research was to revise the existing, rigid level of service guide for LTPCS and to establish acuity-based tiered limits on the total cost of EDA recipients' care plans. This led to the development of a new case-mix allocation system known as SHARe (Service Hours Allocation of Resources). The SHARe system is described below.

In order to implement any changes in the LTPCS program or the EDA waiver, DHH had to re-negotiate the terms of the Barthelemy Settlement Agreement. This settlement agreement also governed aspects of the EDA waiver program. In the spring of 2008, OAAS staff and DHH Legal staff began meeting with the plaintiffs in the lawsuit. After considering a variety of options, an agreement was reached to allow a reduction in the maximum number of hours of LTPCS allowed, in conjunction with applying the new resource allocation method to both LTPCS and the EDA waiver. This agreement led to a Second Supplemental Agreement, which was approved by the federal court in the fall of 2008. The Agreement provides that:

- The maximum number of hours of LTPCS is reduced from 56 to 42 a week.
- DHH may limit expenditures for EDA waiver participants as needed to achieve cost-effectiveness.

- The method of offering EDA waiver slots is changed so that persons already receiving other community based services are a lower priority than those on the waiting list who are not receiving any services.
- Savings from implementing reductions in EDA services will be used to fund new slots and address the waiting list.

Since that time, OAAS has worked with Medicaid to develop the necessary rules, waiver amendments, and state plan amendments to implement SHARe. In addition, OAAS has worked with stakeholders, including providers and support coordination agencies to modify the assessment and care planning processes in a way that support the new methodology.

In October of 2008, OAAS presented the SHARe methodology to a stakeholder group of advocacy organizations for input and feedback.

In December of 2008, OAAS re-trained and began a certification process for, all persons who perform the MDS-HC assessment. This is to ensure that the assessment on which the allocation is based is done correctly.

In January of 2009, OAAS adopted a new person-centered planning approach. Training of assessors and care planners in this new approach began and is ongoing.

ANTICIPATED OUTCOMES

OAAS believes that implementation of the SHARe model will result in the following:

- Reduction of the time that people wait for services
- Increase in the number of people served with current resources
- Stabilization of waiver costs
- Restoration of cost-effectiveness to the EDA waiver
- Reduction of the average EDA waiver costs per slot from current average of $40,947 to an estimated Resource Allocation Model Average of $ 33,000
- Lowering of the average cost per person of LTPCS services
- Slowed growth in LTPCS expenditures

OAAS analyses indicate that, under the new methodology, 65% of non-waiver LTPCS program participants will receive a reduction in hours, and the remaining 35% will have the option to receive more hours. The average change will be a decrease of less than 3 hours per week. In addition, 80% of EDA recipients will see a reduction in their approved services while the remaining 20% will have the opportunity to receive additional services. OAAS will monitor outcomes of the new methodology closely, both to confirm effectiveness in meeting federal cost-effectiveness guidelines while serving more people, and to monitor impact on participant outcomes and ability to remain in the community.

CURRENT STATUS

On January 20, 2009, DHH published emergency rules to implement SHARe in LTPCS and the EDA waiver. The state plan amendment reducing LTPCS from 56 hours maximum to 42 hours has been submitted to CMS. Required legal notices to Medicaid recipients have been sent out and this change will go into effect on March 1, 2009. It will apply to new recipients immediately and will be applied to current recipients upon their annual re-assessment.

DHH has submitted a waiver amendment to the Centers for Medicare & Medicaid Services (CMS). Approval of the amendment is expected in time to allow implementation in the EDA waiver by March 1, 2009. As with LTPCS, the new methodology will apply to new recipients immediately and will be applied to current recipients upon their annual re-assessment.

OTHER COST CONTROL INITIATIVES UNDERTAKEN BY OAAS

- Implementation of shared supports in EDA/LTPCS - Shared supports allow one worker to provide personal care or companion service to two or more clients in the same household, thus reducing the total hours provided. Shared supports are not prohibited in LTPCS, but very few providers are aware of this option. OAAS issued a policy reminder to providers and support coordinators. OAAS has promulgated a rule and amended the waiver to also allow this option in EDA services.

- Implementation of a Self-Directed Personal Care State Plan option - This is a new program authorized by Congress which allows states to offer self-directed personal care services. The service will be offered as an option to LTPCS applicants. Conclusions, based on findings of the evaluation of the programs in other states, show that the self-directed model improves the lives of seniors and people with disabilities as well as their families and caregivers. Evaluations also showed that self-direction did not cost more than the traditional agency-based services and in fact, decreased overall Medicaid costs overtime. A rule was finalized and promulgated in November 2008. A state plan amendment was submitted to CMS on December 31, 2008. Upon CMS approval, the Louisiana Personal Options Program (La-POP) will be piloted in Region 2. If the pilot is successful, it will be expanded statewide.

- Upgrade of training for assessors and case managers - OAAS has developed an enhanced training and competency-based certification process for persons who conduct assessments. This will improve the validity and reliability of assessments, which is important to the success of the new resource allocation plan. OAAS is also developing a new care planning process, with a focus on enhancing, not replacing informal supports.

DESCRIPTIONS OF LEVELS BASED ON RESOURCE UTILIZATION GROUPS

Glossary of Terms:

Activities of Daily Living (ADLs): Activities of daily living are activities related to personal care and include bathing or showering, dressing, getting in or out of bed or a chair, using the toilet, and eating.[1]

Instrumental Activities of Daily Living (IADLs): Instrumental activities of daily living are activities related to independent living and include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone. [2]

Minimum Data Set for Home Care (MDS-HC): Person-centered assessment for individuals in home and community based settings focuses on the person's functioning and quality of life.

Resource Utilization Groups (RUG): Groupings determined by the MDS-HC assessment. Persons are grouped according to similar expected resource utilization based on needs identified in the MDS-HC assessment. Each of the seven major RUG groupings is further divided into sub-groupings based upon ADL and IADL scores on the MDS-HC assessment. These sub-groupings facilitate further individualized determination of expected resource utilization.

- **ADL Sub-grouping:** This sub-grouping is derived from the assessment findings for the four late loss ADLs: eating, toileting, transferring and bed mobility.
- **IADL Sub-grouping:** The IADL sub-grouping is derived from the assessment findings in meal preparation, medication management and phone use.

Levels:

The SHARe resource allocation system, based on Resource Utilization Groups, contains seven basic levels to which individuals are assigned. Those seven levels are described below. Each of these levels is further divided in sub-groupings based on the person's level of ADL & IADL need. This results in a total of twenty-three (23) levels to which individuals are assigned. Each level is associated with has a specific number of LTPCS hours per week. The seven major levels are described below.

Special Rehabilitation

Persons grouped in the Special Rehabilitation categories have had at least 120 minutes of rehab therapy (Physical, Occupational, or Speech) within the 7 days prior to their MDS-HC assessment.

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[1] http://www.cdc.gov/nchs/datawh/nchsdefs/ADL.htm

[2] http://www.cdc.gov/nchs/datawh/nchsdefs/iadl.htm

Revised 12-08-08
Sub-group explanation of IADL / ADL added (JS)

Extensive Services
Persons grouped in the Extensive Services categories are those with medium to high level of ADL need along with one or more of the following services:

- Tracheostomy
- Ventilator/Respirator
- IV feeding
- Suctioning

Special Care
Persons grouped in the Special Care categories are those with medium to high level of ADL need along with one or more of the following conditions or treatments:

- Stage 3 or 4 pressure ulcers
- Tube feeding
- Diagnosis of multiple sclerosis
- Quadriplegia
- Septicemia
- Treatment of burns
- Radiation treatment
- IV Medications
- Fever and one or more of:
    - dehydration
    - diagnosis of pneumonia
    - vomiting
    - unintended weight loss

Clinically Complex
Persons grouped in the Clinically Complex categories are those with specific clinical diagnoses or treatments:

- Aphasia (inability to express thought by means of speech; a consequence of certain brain disorders)[3]
- Dehydration
- Any stasis ulcer (a breakdown of the skin caused by fluid build-up in the skin from poor circulation)[4]
- End-stage/terminal illness
- Chemotherapy
- Blood transfusion
- Skin problem
- Diagnosis of cerebral palsy
- Diagnosis of urinary tract infection

[3] http://encarta.msn.com/encyclopedia_761561521/Aphasia.html
[4] http://www.visualdxhealth.com/adult/stasisUlcerVenousUlcer.htm

- Diagnosis of hemiplegia (total or partial inability to move experienced on one side of the body caused by brain disease or injury)[5]
- Internal bleeding
- Dialysis treatment
- Diagnosis of pneumonia
- One or more of the seven criteria in Special Care (with low ADL need)
- One or more of the three criteria in Extensive Services (with low ADL need)

Behavior Problems

Persons grouped in the Behavior Problems categories are those with low to medium ADL need along with behavior problems.

For example, those individuals that may have socially inappropriate behavior, are physically or verbally abusive, have hallucinations or exhibit wandering behavior.

Impaired Cognition

Persons grouped in the Impaired Cognition categories are those with low to medium ADL need along with impairment in cognitive ability.

For example, this grouping will include persons with short-term memory loss, trouble in decision-making, difficulty in making themselves understood by others, and in eating performance.

Reduced Physical Function

Persons grouped in the Reduced Physical Function category are those that did not fall into one of the previous categories.

[5] http://encarta.msn.com/dictionary_1861617401/hemiplegia.html?partner=orp

Regular Session, 2008 **ENROLLED**

SENATE RESOLUTION NO. 180

BY SENATOR MOUNT

A RESOLUTION

To urge and request that the Department of Health and Hospitals develop and implement cost control mechanisms for the Long-Term Personal Care Services program and the New Opportunities Waiver and to provide interim progress reports as requested by the Senate Committee on Health and Welfare and to submit a written report and presentation to the Senate Committee on Health and Welfare at least forty-five days prior to the convening of the 2009 Regular Session.

WHEREAS, it is in the best interest of the state to operate a cost-effective and high-quality home and community-based services program for citizens who are elderly or have developmental disabilities; and

WHEREAS, the Senate of the Louisiana Legislature finds that, without restructuring of current programs, the sustainability of long-term care and home and community-based services is threatened, and the ability of the state to meet the growing needs of these citizens will be impaired; and

WHEREAS, two programs within the Department of Health and Hospitals pose the greatest risk to the financial sustainability of long-term care services: the Long-Term Personal Care Services program and the New Opportunities Waiver; and

WHEREAS, the Long-Term Personal Care Services program, administered by the office of aging and adult services, provides support in-home to people who are Medicaid eligible and need assistance with the activities of daily living; and

WHEREAS, the Department of Health and Hospitals added Long-Term Personal Care Services as an optional state plan service to its Medicaid program in 2003 and since its inception the number of personal care service agencies has risen significantly, taxing the ability of the department to properly regulate the program and ensure that the clients of the program are receiving appropriate care; and

WHEREAS, the number of eligible applicants for the program has greatly exceeded expectations, resulting in rapid growth in program expenditures and with the passage of the federal Deficit Reduction Act of 2005 state Medicaid agencies have new options for developing state plan home and community-based services that are cost-effective; and

WHEREAS, the New Opportunities Waiver, administered by the office for citizens with developmental disabilities, provides a wide range of supports and services for people with developmental disabilities in order to remain in the community; and

WHEREAS, Louisiana's per person cost for the New Opportunities Waiver is significantly higher than the national average cost of comprehensive waivers; and

WHEREAS, the waiting list for New Opportunities Waiver services continues to grow and in order to sustain current services and to reduce the wait for services, the state of Louisiana will have to take necessary steps to assure that the New Opportunities Waiver program is cost-effective; and

WHEREAS, the annual expenditures of both the Long-Term Personal Care Services program and the New Opportunities Waiver have grown substantially despite the efforts of the department to implement fiscal controls; and

WHEREAS, absent the enactment of cost control mechanisms in the Long-Term Personal Care Services program and the New Opportunities Waiver, the ability of the state to meet the demand for services is of concern, thereby potentially subjecting the state to litigation and continued growth in expenses with the additional detriment of not serving more people.

THEREFORE, BE IT RESOLVED that the Senate of the Louisiana Legislature hereby urges and requests the Department of Health and Hospitals to develop and implement mechanisms to provide the most cost-effective means of financing for the Long-Term Personal Care Services program and the New Opportunities Waiver.

BE IT FURTHER RESOLVED that the Department of Health and Hospitals shall consider typical mechanisms and strategies that have been successfully utilized in other states to assure sustainability of home and community-based services and these mechanisms and strategies may include but shall not be limited to:

(1) Uniform needs-based assessments.

(2) Resource allocation models based on uniform needs-based assessments.

(3) Containment on individual expenditures.

(4) Utilization of any appropriate options made available through the Deficit Reduction Act of 2005.

(5) Development and implementation of new, more cost-effective waivers.

(6) Programmatic and fiscal utilization reviews for efficiencies in administrative and programmatic resource allocation.

BE IT FURTHER RESOLVED that the Department of Health and Hospitals shall provide interim status reports as requested by the Senate Committee on Health and Welfare and submit a written report and presentation to the Senate Committee on Health and Welfare at least forty-five days prior to the convening of the 2009 Regular Session which outlines the progress of the Department of Health and Hospitals in developing and implementing the selected cost control mechanisms.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the Department of Health and Hospitals.

PRESIDENT OF THE SENATE