Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

March 9, 2010

The Honorable Joel T. Chaisson, II, President
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

Dear President Chaisson:

In response to House Concurrent Resolution No. 190 (HCR 190) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. HCR No. 190 directs DHH to conduct an evaluation of adult day health care reimbursement and services in Louisiana. The resolution also requests that DHH convene an adult day health care advisory council to assist DHH with this charge.

The office of aging and adult services within DHH is available to discuss the enclosed report and recommendations with you at your convenience. Please contact Hugh Eley, assistant secretary of the office of aging and adult services, at (225) 219-0223 with any questions or comments you may have.

Sincerely,

Alan Levine
Secretary

Enclosures

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

March 9, 2010

The Honorable Jim Tucker, Speaker
Louisiana State House of Representatives
P.O. Box 94062, Capitol Station
Baton Rouge, LA 70804-9062

Dear Speaker Tucker:

In response to House Concurrent Resolution No. 190 (HCR 190) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. HCR No. 190 directs DHH to conduct an evaluation of adult day health care reimbursement and services in Louisiana. The resolution also requests that DHH convene an adult day health care advisory council to assist DHH with this charge.

The office of aging and adult services within DHH is available to discuss the enclosed report and recommendations with you at your convenience. Please contact Hugh Eley, assistant secretary of the office of aging and adult services, at (225) 219-0223 with any questions or comments you may have.

Sincerely,

Alan Levine
Secretary

Enclosures

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

March 9, 2010

The Honorable Willie L. Mount, Chair
Senate Health and Welfare Committee
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

Dear Madam Chairman:

In response to House Concurrent Resolution No. 190 (HCR 190) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. HCR No. 190 directs DHH to conduct an evaluation of adult day health care reimbursement and services in Louisiana. The resolution also requests that DHH convene an adult day health care advisory council to assist DHH with this charge.

The office of aging and adult services within DHH is available to discuss the enclosed report and recommendations with you and the members of the Senate Health and Welfare Committee. Please contact Hugh Eley, assistant secretary of the office of aging and adult services, at (225) 219-0223 with any questions or comments you may have.

Sincerely,

Alan Levine
Secretary

Enclosures

Bobby Jindal
GOVERNOR

Alan Levine
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

March 9, 2010

The Honorable Kay Katz, Chair
House Health and Welfare Committee
Louisiana State House of Representatives
P.O. Box 44486, Capitol Station
Baton Rouge, LA 70804-4486

Dear Madam Chairman:

In response to House Concurrent Resolution No. 190 (HCR 190) of the 2009 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. HCR No. 190 directs DHH to conduct an evaluation of adult day health care reimbursement and services in Louisiana. The resolution also requests that DHH convene an adult day health care advisory council to assist DHH with this charge.

The office of aging and adult services within DHH is available to discuss the enclosed report and recommendations with you and the members of the House Health and Welfare committee. Please contact Hugh Eley, assistant secretary of the office of aging and adult services, at (225) 219-0223 with any questions or comments you may have.

Sincerely,

Alan Levine
Secretary

Enclosures

DEPARTMENT OF HEALTH AND HOSPITALS

EVALUATION OF ADULT DAY HEALTH CARE SERVICES AND REIMBURSEMENTS

REPORT PREPARED IN RESPONSE TO HCR 190 OF THE 2009 REGULAR SESSION

JANUARY 2010

Contact:
Louisiana Department of Health and Hospitals
Hugh R. Eley
Office of Aging and Adult Services
PO Box 2031, Baton Rouge, LA 70821-2031
225-342-0095
Hugh.Eley@La.Gov

EXECUTIVE SUMMARY

House Concurrent Resolution 190 of 2009 directs the Department of Health and Hospitals (DHH) to evaluate Adult Day Health Care (ADHC) services and reimbursement in Louisiana, and to submit a report on "the implementation of this Resolution and the results of the reviews and evaluations conducted pursuant to this Resolution" to House and Senate committees on health and welfare. Specific mandates contained in the resolution are:

1) Reconsider the rate reduction proposed for Fiscal Year 2009-2010
2) Implement a facility need review (FNR) process for ADHC centers seeking to enroll in Medicaid
3) Conduct an independent review of the ADHC program to include study of
    a. Rate Methodology
    b. Reimbursement Methodology (including the "five hour rule" requiring that an ADHC participant remain at the center for at least five hours in order for the provider to be reimbursed under Medicaid)
    c. Scope of Service
    d. Client Outcomes
4) Examine the process by which individuals access or apply for ADHC services

HCR 190 also mandated establishment of a 15 member advisory council to provide input to DHH in implementing the resolution.

Actions Responsive to HCR 190

1) Though reductions to provider rates were discussed during the 2009 Regular Session, no cuts were passed or implemented. Though costs for support coordination were removed from the ADHC rate in January, 2009; subsequent rebasing effective SFY10 essentially restored the ADHC daily rate to its previous level.
2) DHH published the Notice of Intent to establish rules for ADHC Facility Need Review (FNR) in September, 2009. The final rule for ADHC FNR is scheduled for publication in the February 20, 2010 Louisiana Register. The proposed rule would require applicants for licensure to first submit data and other evidence demonstrating probability of serious, adverse consequences to recipients' ability to access adult day health care if the applicant is not allowed to be licensed. In reviewing the application, DHH may consider factors such as the number of ADHC providers in the same geographic location serving the same population, and allegations involving issues of access to health care and services. The FNR application must be approved before an applicant can seek ADHC licensure.
3) The advisory council examined issues in the areas of rate and reimbursement methodology, scope of services, access, and client outcomes. OAAS staff provided information to the advisory council specific to ADHC centers in Louisiana, as well as norms and best practices for adult day health care gleaned from the national literature.

Recommendations, including elimination of the five-hour rule, can be found in the conclusions section of this report.

REPORT TO THE LEGISLATURE

INTRODUCTION

PURPOSE AND PARAMETERS OF REPORT

House Concurrent Resolution 190 of 2009 directs the Department of Health and Hospitals (DHH) to evaluate Adult Day Health Care (ADHC) services and reimbursement in Louisiana, and to submit a report on "the implementation of this Resolution and the results of the reviews and evaluations conducted pursuant to this Resolution" to House and Senate committees on health and welfare. Specific mandates contained in the resolution are that the Department:

1) Reconsider the rate reduction proposed for Fiscal Year 2009-2010
2) Implement a facility need review process for ADHC centers seeking to enroll in Medicaid
3) Conduct an independent review of the ADHC program to include study of
    a. Rate methodology
    b. Reimbursement methodology
    c. Scope of service
    d. Client outcomes
    e. Access to ADHC services

A discrete aspect of reimbursement methodology highlighted for study under the resolution is the "five-hour rule" requiring that an ADHC participant remain at the center for at least five hours in order for the provider to be reimbursed under Medicaid.

HCR 190 further directs the Department to "convene an adult day health care advisory council for the purpose of providing input and feedback to the department in implementing this resolution." Membership of the Advisory Council is specified in the resolution and summarized in Table #1.

TABLE #1
Adult Day Health Care Advisory Council Membership

Hugh Eley Assistant Secretary of the Office of Aging and Adult Services (OAAS)	Cindy Rogers Representative of an adult day health care center that is not affiliated with LADSA and appointed by OAAS
Ray Dawson Medicaid Director designee	Nell Hahn Advocacy Center
Carolyn Dell Medicaid Health Standards Section designee	Kerry Everitt AARP
Kent Bordelon, Medicaid Rate and Audit Section director	Jay Bulot Executive Director of the Governor's Office of Elderly Affairs

Allison Vuljoin
Member of the quality improvement section of the OAAS

John Ford
President of the Louisiana Adult Day Services Association (LADSA)

Ruth Hubbard
Representative of a free-standing adult day health care center appointed by LADSA

Kathleen Leach
Representative of a hospital affiliated adult day health care center appointed by LADSA

KaraLe Causey
Medical professional specializing in geriatric care appointed by the Louisiana Geriatric Society

Ruth Fontenot
Alzheimer's Association

Tony Keck
Governor's advisor on health policy

~~~

Though HCR 190 does not specifically call for recommendations, this report concludes with recommendations based upon independent review and evaluation, and on feedback from the Advisory Council. Recommendations are grouped into four areas:

1) Licensing (which addresses Scope of Services)
2) Rate Methodology
3) Payment Methodology
4) Access

The report also provides background and history on the ADHC program in Louisiana, places the program in a national context, and addresses Department action on the two other issues indentified in HCR 190, namely the proposed rate reduction and facility need review.

IMPLEMENTATION OF HCR 190

As the operating agency for the Medicaid ADHC program in Louisiana, the DHH Office of Aging and Adult Services (OAAS) was assigned responsibility for implementing HCR 190. OAAS convened the Advisory Council according to the directives of the resolution (i.e., the Council was convened prior to August 14, 2009) and has met more than the minimum six times required by the resolution. To support the review and evaluation called for in the resolution, OAAS staff compiled significant existing research and reports on both the ADHC program in Louisiana and on best practice and status of ADHC programs and services nationally. This information was shared with the Council both at initial orientation and as specific topics were addressed. "Independent review" of Louisiana's ADHC program consisted of the following:

> **Rate and Reimbursement Methodology**. A nationally recognized actuarial firm, Myers and Stauffer, was engaged to prepare analyses of the current ADHC rate method under Medicaid and to model alternative methods based on a variety of factors identified by the Advisory Council. Myers and Stauffer also provided information about methodologies used by other states.
~~~

Scope of Service and Access. OAAS contracted with the Gerontology Institute at the University of Louisiana, Monroe (ULM) to conduct an independent study of ADHC services. The first phase of the study consisted of an electronic survey of all 37 licensed ADHC providers in the state and was completed in time for inclusion in this report. Additional study through on-site observation of a representative sample of 9 ADHC centers is planned and should be completed in March. Centers for the on-site sample were selected to represent variation in size, location (all regions of the state included as well as urban and rural centers), affiliation, and profit status.

Client Outcomes. Data on client outcomes was obtained through independently conducted, face-to-face consumer surveys with a statistically valid sample of ADHC participants served under Medicaid. Additional outcome data was obtained through analysis of Medicaid claims and client assessment data.

The Advisory Council had input on the conduct of the independent review, identifying the factors to be analyzed by Myers and Stauffer and providing feedback on the electronic survey used by ULM. Findings of the independent reviews were shared with the Council.

BACKGROUND

PROGRAM DESCRIPTION

Louisiana's Adult Day Health Care waiver is Louisiana's oldest Medicaid waiver program targeting elders and people with adult-onset disability. It was started in 1985 and serves individuals 65 and older or age 22-64 with disabilities who meet Medicaid Long Term Care financial eligibility standards and who meet medical criteria for admission to a nursing facility (i.e., nursing home "level of care").

Louisiana has 37 licensed ADHC centers; 34 of these are enrolled Medicaid providers. Three centers rely entirely on other non-Medicaid payer and revenue sources. Medicaid expenditures for ADHC are summarized in Table #2.

TABLE #2 - ADHC Expenditures (actual)

SFY	Amount	SFY	Amount
99-00	$2,225,061	04-05	$6,746,957
00-01	$2,550,576	05-06	$5,185,531
01-02	$3,395,755	06-07	$6,846,248
02-03	$3,854,870	07-08	$7,301,592
03-04	$5,694,664	08-09	$7,602,881

~~~

Waiver Opportunities (Slots)

- There are currently 825 allocated ADHC waiver opportunities (slots).
- As of February 1, 2010, there were 724 recipients who receive ADHC waiver services for a utilization rate of 88%.
- As of February 1, 2010, offers were being made to persons with a request date of August 31, 2009.
~~~

Services

Direct services covered under this waiver are center-based and provided by staff at a licensed ADHC center. Per current licensing standards, ADHC services include:

- Transportation
- Health Services
- Nursing Care and Oversight
- Personal Care (assistance with personal tasks such as toileting and transfer)
- Social Services
- Nutritional/Dietary Services

Additional services added to the ADHC waiver in 2007 are:

- Support Coordination
- Transition Intensive Support Coordination
- Transition Services

Transition services and intensive support coordination are designed to assist individuals who are transitioning out of a nursing home into the community.

LOUISIANA COMPARED TO ADHC NATIONALLY[1]

Participant Profile

The population served by Louisiana ADHCs is fairly consistent with the population served nationally. The average ADHC participant nationally is 72 years old; current average participant age in Louisiana in 2008 was 72.5. According to a Robert Wood Johnson Foundation (RWJF) funded national survey of ADHCs, 52% of participants are diagnosed with dementia, 37% need assistance with walking, 24% with eating, and 43% with toileting. Assessment data for Louisiana ADHC participants indicates that 42% are diagnosed with dementia, 56% require at least limited assistance with locomotion, 17% with eating, and 63% with toileting.

Service Model

The literature on Adult Day Care tends to recognize three models. **(1)*Social Model*** ADHC provides minimal health and medical services and minimal assistance with personal care tasks. Because of this, best-practice emphasizes that social model licensing and admission standards must be clear about who can and cannot be served in such centers. Social model centers typically serve individuals with mild to moderate cognitive impairment who benefit from social programming and supervision but who have few if any medical problems and little physical impairment. **(2) *Medical Model*** centers, on the other hand, may offer a range of nursing, therapies, and medical services in addition to assistance with personal care tasks. These services may be as extensive as wound care and intravenous (IV) infusions. In between these two models are centers that identify themselves as **(3) *Combination Model*** ADHC. Nationally, 21% of ADHCs are identified as medical, 37% as social, and 42% as combination. According to Peter Notarstefano, Director for Home and

[1] National data in this section are from the 2001-2002 Adult Day Center Survey conducted by Wake Forest University School of Medicine Partners in Caregiving program funded by the Robert Wood Johnson Foundation.

Community Based Services at the American Association of Homes and Services for the Aging (AAHSA), and Morgan Gable, AAHSA policy analyst, Louisiana's licensing requirements reflect a combination model of ADHC tending more towards social than medical model care. A comparison of Louisiana's licensing requirements to those of other Southern states can be found in Table #3.

TABLE #3 - ADHC Licensing Requirements Comparison

	Louisiana	Texas	Alabama	Florida	Kentucky	North Carolina
Required staff	Director RN or LPN Social Service designee Food service designee Program Manager Direct Service Worker Consulting dietician	Facility Director RN or LVN Program Director Attendants Consulting dietician	RN or LPN 2 hrs per week	RN or LPN Social Worker Activity Director or RT	RN or LPN Administrator	Program director Health Care coordinator (RN or LPN) Nurse aide or home health aide Consulting dietician
Staff/client ratio	1:9	1:8	1:10 to 1:12	1:6	Adequate	1:8
Staff training	20hrs/yr.	18 hrs initial 12 hrs annual	None specified	3 hrs Alzheimer's disease	A planned program, no hours specified	None specified
Minimum Day	5 hours	None	7 hours	5 hours	Not specified	6 hours
Required services	Nursing, medical, and social services ADL Assistance or training Medication administration or supervision Daily meal and snacks Varied activity program Daily rest period Daily health education Daily exercise Monthly vital signs Transportation	ADL Assistance or supervision Medication Administration Meals Rehabilitative exercise Community integration 3 activities/day Transportation	Medication assistance At least 4 hrs. indoor and outdoor varied activities Meals and snacks Information Socialization Physical activity and mental stimulation Transportation	Social & health activities Leisure activities Self care training Daily rest period Meals Respite	Health monitoring Arranging transportation PT, ST, OT Nursing services (after 2001) Recreation and exercise Mental stimulation Diversion ADL assistance and training One meal	Health monitoring ADL assistance or training Medication administration Special feeding Bowel & bladder program Tracheostomy care Nurse delegation Activities Daily exercise (ROM) Health education meal
Medicaid Rate	$64.40/day	$18.95 - 19.95/day	$18-25/day		$2.57 per 15 min. unit $82.24 per day	$50 per day

~~~

The National Adult Day Services Association provides a similar conceptualization of adult day care models or "tiers" as described in Table #4. It should be noted that in the "Core" tier, "health
~~~

related services" are not nursing services. Rather, Adult Day Service providers collect, maintain and update – within the scope of practice of the staff involved – medical and functional information and assessments. For those areas outside of the scope of practice of the staff involved, the center maintains a file and notifies others when assessments and other medical and functional reports are due.

TABLE #4 NADSA Tiers

Scope of Services
National Adult Day Services Association

Core	Enhanced	Intensive
Assessment & care planning Assistance with ADLs Health related (non-nursing) services Social services Therapeutic Activities Nutrition Transportation Emergency care	*Add all or some of the following:* Restorative, supportive or rehabilitative nursing care on an intermittent basis Assessment and referral to psychosocial services and follow-through with treatment PT, OT and St for maintenance	*Add all or some of the following:* Intensive nursing care for unstable conditions Therapies at a restorative or rehabilitative level Intensive psychosocial services Specialized supportive services

~~~

Legislation pending in Congress (House Bill 3043) would make post-hospitalization sub-acute services delivered in ADHCs eligible for Medicare reimbursement. To receive reimbursement for these services, ADHCs would have to meet state licensing requirements, and services would have to comport with the same prospective payment systems and other requirements/regulations as services provided by Home Health Agencies. Medicare would be a significant new payer source and revenue stream for ADHCs. ADHC ability to expand to and serve this population would also expand access to services to a wider population and contribute to institutional diversion.

With the assistance of AASHA, Council members and OAAS staff developed a preliminary description of services that might ideally be provided under social and medical models of ADHC (Table #5).
~~~

TABLE #5 – Description of Services

Social Model ADHC Services	Medical Model ADHC Services
Staffing • No clinical staff required • Sufficient staffing to be able to care for clients with dementia Required Services • Basic ADL assistance (but not training) • Medication prompting and assistance with self administration • Recreation • Weekly nursing assessment • Dementia capable • Meals (complex special diets or special feeding not required) • Activities • Exercise • Meals • Respite • Caregiver support and I&R	Staffing • RN on site or and LPN on site with RN supervision • A Medical Director is required • PT/ST/OT available either through on-site staff or through contracts • Care planning done by an Interdisciplinary Team that includes an MSW, Medical director, RN, and client, as a minimum • The national average staff ratio is 1:7 • A dietician is involved in meal planning • A consultant pharmacist provides monthly medication reviews • A recreation therapist may be required Required services o Nursing o Medical monitoring o ADL assistance & training o Medication management o Preventive/Wellness Care o Rehabilitation Services (including bowel and bladder) o Access to Social Work Services o Dietary Services o Therapeutic recreation o Transportation o Dialysis management

~~~

Business Model

The profile of Louisiana ADHCs differs from the national profile in several ways that are relevant from a business model perspective.

Profit status. Seventy-eight percent of ADHCs nationwide are non-profit compared to 54% in Louisiana.

Affiliation. Nationally, 70% of ADHC centers are affiliated with a parent organization such as a nursing home (17%), multi-service senior service organization (13%), hospital (10%), or religious organization (10%). In Louisiana, only 38% of ADHCs are affiliated. The balance are stand-alone, though a few also offer other Medicaid services such as Long-Term Personal Care Services. Affiliation is significant in that the Robert Wood Johnson Foundation found that ADHC providers who were not affiliated with a larger organization
~~~

within which costs were shared, or who did not have additional lines of business, tended to struggle financially.

Days and Hours of Operation. Because of the center-based nature of services, ADHCs can be an invaluable resource and source of respite for family caregivers, especially family caregivers who work outside the home. For this reason, days and hours of operation have a significant impact on center utilization and ability to attract multiple revenue streams and payor sources. Nationwide, 77% of centers are open 5 days a week, 11% are open 6 days a week, and 6% are open 7 days. Forty-three percent of centers have weekday operating hours 8 to 9.5 hours per day, 39% are open 10 hours are more. In Louisiana, hours of operation range from 6 to 11 hours per day.

Payor and Revenue Sources – Compared to ADHC nationally, many Louisiana ADHC providers are heavily dependent on Medicaid as their primary, or even single, payor source. The Robert Wood Johnson Foundation found that nationally, public reimbursement constitutes only 38% of the revenue stream for ADHCs, with private pay constituting 35%. Other sources of revenue include grants, donations, reimbursement through private insurance, and revenue from provision of ancillary services. In Louisiana, Medicaid alone accounts for 67% of total revenue for ADHC providers. Though not an ancillary service under the ADHC license, several ADHC providers in Louisiana are also licensed to provide personal care services. For those that do provide personal care, Medicaid is also the major funding stream for this service. Table #6 summarizes revenue sources for Louisiana ADHC services.

TABLE #6 – Revenue Sources for Louisiana ADHC Services

Center Type	Medicaid	Medicare	Private Pay	Other	Total	Medicaid
ADHCs part of multi-service agencies (10)	$ 1,406,783	$ 563,805	$ 1,582,030	$ 92,209	$ 3,644,827	39%
Stand alone Non-profits (6)	$ 1,481,091	$ -	$ 206,034	$ 127,599	$ 1,814,724	82%
For profit ADHCs (12)	$ 3,268,116	$ -	$ 490,958	$ 36,605	$ 3,795,679	88%
Total	**$ 6,155,990**	**$ 563,805**	**$ 2,279,022**	**$ 256,413**	**$ 9,255,230**	**67%**

~~~
~~~

ADHC POLICY AND PROGRAM DEVELOPMENT

Licensing/Regulatory Authority

During the 2007 Legislative Session, DHH cooperated with providers to pass legislation creating a separate license for ADHC and imposing a moratorium on new providers. ADHC providers were previously licensed under rules based upon the "adult day care" licensing statute that applied primarily to day programs for persons with developmental disabilities. During the 2008 Session, DHH worked with providers to clean up language in the 2007 Act that was problematic, including a change that removed the five hour per day minimum requirement from the statute. This cleared the way for DHH to consider alternative ways of paying for ADHC services.

Subsequently, DHH promulgated two separate rules concerning the provision of ADHC services. Found in Title 48 of the Louisiana Administrative Code and published as final in the December 2008 Louisiana Register, one rule governs licensing, which is required for all ADHC providers, regardless of payor source. The other rule, found in Title 50 of the Louisiana Administrative Code and published as final in the December 2008 Louisiana Register, applies to Medicaid enrolled ADHC's providing services under the ADHC Waiver, and includes:

- Setting forth waiver provisions such as service definitions and registry, waiver, and discharge criteria
- Removing provisions which duplicated the licensing standards for ADHC providers
- Establishing support coordination, transition services, and transition intensive support coordination as separate services in the ADHC Waiver

Federal Compliance and Support Coordination in ADHC Waiver

The federal agency charged with overseeing the ADHC Waiver (as well as all waivers in the State of Louisiana) is the Centers for Medicare and Medicaid Services (CMS). At least every five years, Louisiana must renew its application to CMS for approval of any waiver it operates.

In 2007, DHH submitted a renewal of the ADHC waiver to CMS. Included as additional services in the ADHC Waiver was Support Coordination (along with Transition Intensive Support Coordination and Transition Services). Prior to renewal, DHH was urged by CMS to add Support Coordination. This was based partly on CMS' concern that an inherent conflict of interest existed because while ADHC providers provided support coordination-like services, they also provided direct care services. This is compounded by the fact that 11 current ADHC providers also provide in home services through the LT-PCS program.

CMS also recommended that DHH implement Support Coordination as a separate service because it is deemed best practice nationally to do so.[2] From a federal and best-practice perspective, independent Support Coordination best ensures that:

- Plans of Care for recipients are comprehensive in nature (i.e. that they include all services, not just ADHC)

[2] All waivers within Louisiana contain support coordination.

- Individuals who wish to transfer to another ADHC facility or to another waiver will have someone to assist them
- Individuals are informed of other available services and have someone to assist them with accessing other needed services
- A contact person for assistance with services is available 24 hours a day/7 days a week
- Services received by the recipients are monitored.
- The transfer, closure and discharge process is expedited.

CMS approved the renewal of the ADHC Waiver effective July 1, 2007.

After renewal, CMS inquired about the status of DHH's efforts to implement Support Coordination in the ADHC waiver. After discovering that it had not yet been implemented, CMS sent a letter to DHH advising that the department was violating the Medicaid statute's "freedom of choice" provision. DHH was required to submit a corrective action plan to CMS to achieve implementation of support coordination in the ADHC Waiver by January 2009. During this time, DHH formally met with ADHC providers on at least two occasions and informed them of the upcoming implementation of Support Coordination. Implementation was effective January 2009. In April, CMS made a site visit to Louisiana to monitor compliance with the implementation. DHH is awaiting CMS's report on the visit.

An issue that arose during implementation concerned paying for the support coordination services. The current ADHC rates reflect costs reported for conducting the required waiver assessment and completing the comprehensive plan of care. Those functions are now performed by support coordinators, not the ADHC provider. If DHH continued to pay a rate that included those costs, while also paying support coordination agencies, it would be paying for the same function twice. This is not allowed under Medicaid rules. As a result, the support coordination component of $4.66 a day was removed from the $65.45 rate, resulting in a rate of $60.79.

Rate and Payment Methodology

ADHC waiver service providers are paid a daily rate on a fee for service basis. The daily rate pays for a minimum five hour stay at the center. The rate uses a cost-based, prospective payment reimbursement methodology that was developed and implemented in January 2003. The rate methodology is set forth in an administrative rule. The rule requires DHH to examine the need to rebase the rate at least every three years.

Although it was not a "rebase year", DHH implemented a roughly 15% rate increase for ADHC providers in 2005, increasing the daily reimbursement rate to $64.34. This action was taken in response to provider concerns, but without additional legislative funding or mandate. An additional $1.11 was added when the wage pass-through for direct care workers was implemented in February 2007, which raised the total reimbursement rate to $65.45.

As a result of the implementation of support coordination as mandated by CMS (see discussion above), the ADHC reimbursement rate was decreased to $60.79. Pursuant to HCR 190 the rate was now been rebased effective July 1, 2009 to $64.40. According to the 2009 Genworth Cost of Care Survey, which studies health care rates across the country, the median national daily rate for ADHC

is $53.59. Staff with the American Association of Homes and Services for the Aging report a national average daily rate of $64, which includes reimbursement for transportation.

DHH Outreach and Expansion Efforts

Earlier in 2009, DHH added ADHC as a waiver service in the Elderly and Disabled Adult (EDA) waiver. By making this service available in the EDA waiver, the statewide ADHC provider community now has access to over four thousand additional potential recipients. DHH also proposed making the ADHC waiver service package more comprehensive by adding services to the package such as environmental modifications and personal emergency response system. However, these changes were not funded in the current budget.

DHH implemented a prior approval process for ADHC waiver providers on July 1, 2007. By doing so, DHH was able to ensure that only services that met delivery criteria were paid. Further, the data extracted from the prior authorization process allows DHH to obtain data on service utilization that was not previously available. This data has been useful in identifying service utilization trends and will be important in studying alternative means of service delivery and provider reimbursement, such hourly billing for the provision of ADHC services.

REVIEW FINDINGS

RATE AND REIMBURSEMENT

The Louisiana Adult Day Health Care Advisory Council requested that the actuarial firm Myers and Stauffer provide a series of rate modeling studies to assist the committee in making recommendations about how an appropriate ADHC rate (or rates) for Louisiana could be determined. Myers and Stauffer is under contract to DHH to provide consultant services in the area of rate setting, and has helped determine ADHC rates in several states.

Myers and Stauffer first examined the impact of various factors (or "descriptors") on the costs of providing services. The data was drawn from cost reports and acuity data submitted by ADHCs in Louisiana that receive Medicaid reimbursement. Only the 28 centers that had provided complete information for the sample years were included in the analysis. Recipient descriptors included in the analysis were client self-performance of Activities of Daily Living and client cognitive performance. Center descriptors examined were affiliation, size, profit/non-profit status, and location. The analysts then developed a pro forma rate based on a weighted median (rather than the simple median currently used) and outlined additional modeling activities. A brief summary of the modeling studies follows. It should be noted that small sample size makes it more difficult to detect patterns and cost-drivers.

Recipient Descriptors

Using data from the Minimum Data Set-Home Care (MDS-HC), a comprehensive assessment completed and periodically updated for all recipients, a score was obtained for activities of daily living (ADL) with a range of 4 (independent) to 18 (dependent), and for cognitive performance (CPS)with a range of 0 (intact) to 6 (very severely impaired) for each ADHC recipient. In the Louisiana ADHC data analyzed by Myers and Stauffer the highest ADL score was 15 with an overall weighted average of 7.70. The CPS scores range from 0

(cognitively intact) to 6 (very severely impaired cognition) with an overall weighted average CPS score of 2.84. The analysis did not find a strong correlation between these recipient factors and direct care costs.

Center Descriptors

Affiliation. Whether the ADHC was free standing or affiliated with a larger corporation had no impact on direct care or care related costs, but was a factor in administrative and capital costs.

Size. Another potential cost driver is the size of the facility. Are there economies of scale? Should these economies be rewarded in the rate methodology? To help evaluate this, the analysis looked at two measures of size: capacity and number of days of service.

- The average capacity of providers in the analysis is 54. Providers with below average capacity had average direct care and care related costs of $35.03 while providers with above the average capacity had average direct care and care related costs of $32.55.
- The average days of service were 5519. Providers with below average days of service had direct care and care related costs of $37.64 and providers with above average days of service had direct care and care related costs of $29.19. If size were to be incorporated into a rate calculation, it seems it should be based on actual days of service provided rather than on capacity only.

Profit/Not for Profit. Cost differences between profit and not-for-profit in the average direct care and care related per diem appear to not be large enough to require inclusion as a rate parameter.

Location . There does appear to be a significant difference in average direct care costs between urban and rural ADHCs. As the state works to develop the new rate methodology, it could consider a geographic adjustment.

Rate Modeling

Modeling a pro forma rate using day weighted medians rather than simple medians
Because larger centers are able to provide services at lower costs than small centers, weighting the rate for average days of service (as recommended above) would lower the rate as follows: Total PPS Rate - $64.40 Total Pro Forma Rate - $61.57. As this was not an effort to reduce rates but more appropriately establish limits, other rate parameter adjustments could be funded by the difference, or adjustments could be made to the add-on factor to the median in the direct care component. This would allow the state to institute some sort of bonus pay for better outcomes or provide a higher rate to centers that serve recipients with more complex needs without increasing overall costs.

Developing a rate model with a RUG-HC adjustment to direct care

In the model, the acuity adjusted rate would equal the current rate at a Case Mix Index (CMI) equal to the population CMI average, which, in this example is slightly under .98. Providers with CMI below the average rates would be less than the current rate and providers with CMI above the average would get rates greater than the current rate. From comparing costs to this pro forma rate it is obvious that, when considering total costs, there are large variations in reported costs with many factors contributing to differences in addition to acuity.

Additional Recommended Modeling

The following modeling activities should be considered to evaluate potential rate changes:

1) Develop an interactive model to include the following rate parameters. (The interactive model allows for real time inclusion of various rate parameters, adjustments to those parameters, and the ability to estimate fiscal impact to providers and state):
    - Peer groupings such as location, size, or affiliation
    - A tier level acuity system based on ADLs, cognition, or other criteria

2) To accommodate the move to an hourly rather than a per diem rate, the model should include hours of service provided to coincide with cost reports used in the model. Hourly data would be necessary to accurately estimate fiscal impact.

3) The following additional discussion items should be considered when evaluating potential rate changes:

    - Developing an outcome-based quality of care adjustment
    - Timing and accuracy of MDS-HC assessments if used for acuity and/or quality of care adjustments

SCOPE AND ACCESS

In order to build a picture of the variety and depth of services provided by Louisiana's ADHCs, OAAS contracted with the Gerontology Institute at the University of Louisiana at Monroe (ULM) to survey the ADHCs. Dr. Iftekhar Amin of ULM was lead researcher. The survey was conducted as a web-based, self report instrument. Survey responses were received between December 7, 2009 and February 3 2010. Thirty-four of the 37 licensed ADHCs in Louisiana participated. The survey results reported here are preliminary to completion of a final report by ULM.

Most ADHCs in Louisiana are affiliated with organizations that provide more services to their community than just this one Medicaid service. Non-profit centers are often affiliated with a larger social service agency, hospital, or nursing facility. But even for-profit centers are often licensed to provide additional Medicaid-reimbursed services such as personal care assistance, supported independent living, and respite care. Centers also make use of local social services agencies, health

care providers, faith based organizations, recreation programs, and others to enrich their internal programming.

ADHCs are required to provide health related services to their clients. They do this with a combination of staff and contracted services. Though not required services, complex therapies such as physical therapy, speech therapy, occupational therapy, podiatry and dentistry are most often provided under third party contracts. No centers directly employ these therapists, and two centers report having professional service contracts with individual therapists. Of the remaining centers, 8 provide services through a third party, 11 report that the service is unavailable, and 15 did not answer the question.

Centers are required to have a nurse on their staff and can provide a good deal of nursing service directly. Services mentioned by more than one center included vital signs, medication administration, patient and family education, nursing assessments, wound care, and glucose checks. Centers provide a number of other health related services such as specialized meals, exercise, pet therapy, and referrals to medical care.

ADHCs place a great deal of emphasis on the socialization that they provide their clients. There is a vast array of socialization activities reported by the ADHCs. These include activities that occur in the center, such as therapeutic games, crafts, music groups, Bible study; as well as outdoor activities, such as gardening, fishing and outdoor games. Most centers also conduct periodic day trips away from the center's campus. All centers report provision of exercise, crafts, and entertainment (defined as "movies, TV, music, etc.").

While persons as young as 21 are served by ADHCs, the majority of the population served is elderly. Every center reported at least some participants who have dementia. One-third reported that a majority of their participants attend because they have dementia. All centers provide some dementia specific programming.

Most client referrals come by word of mouth or referrals from other clients. The second most common source of clients is by referral form support coordinators and through the waiver linkage process. All of the centers that responded said that they provided transportation to and from the center (two centers did not respond to this question). For five centers, this was the only transportation that they reported. Centers that provided additional transportation reported doing so for the center's trips and outings (22 centers), medical appointments (18 centers), and community services (12 centers).

Hours of operation ranged from six hours a day to eleven. Only three centers report being open less than eight hours per day. Seventeen are open 9 hours per day or more.

The intention is to follow this survey with site visits to a representative sample of ADHCs. This will give the Department the opportunity to clarify the survey reports and gather a firm understanding of the population served, the effective models of care, and the capacity of the centers to meet client needs. This will be necessary to go forward with implementing the recommendations in this report.

CLIENT OUTCOMES

Consumer Satisfaction. During 2009, a survey team under the direction of Dr. Charles S. Gifford, a provider of independent research and survey services, conducted a consumer satisfaction survey among participants in Louisiana's ADHC waiver. The Participant Experience Survey, developed by MEDSTAT Group, Inc. for the Centers for Medicare and Medicaid Services (CMS) was the core of the survey. A statistically valid sample of 264 of 703 ADHC recipients participated in the survey, including recipients from all 9 regions of the state. Survey interviews were conducted face-to-face with participants, either in their home or at the ADHC center.

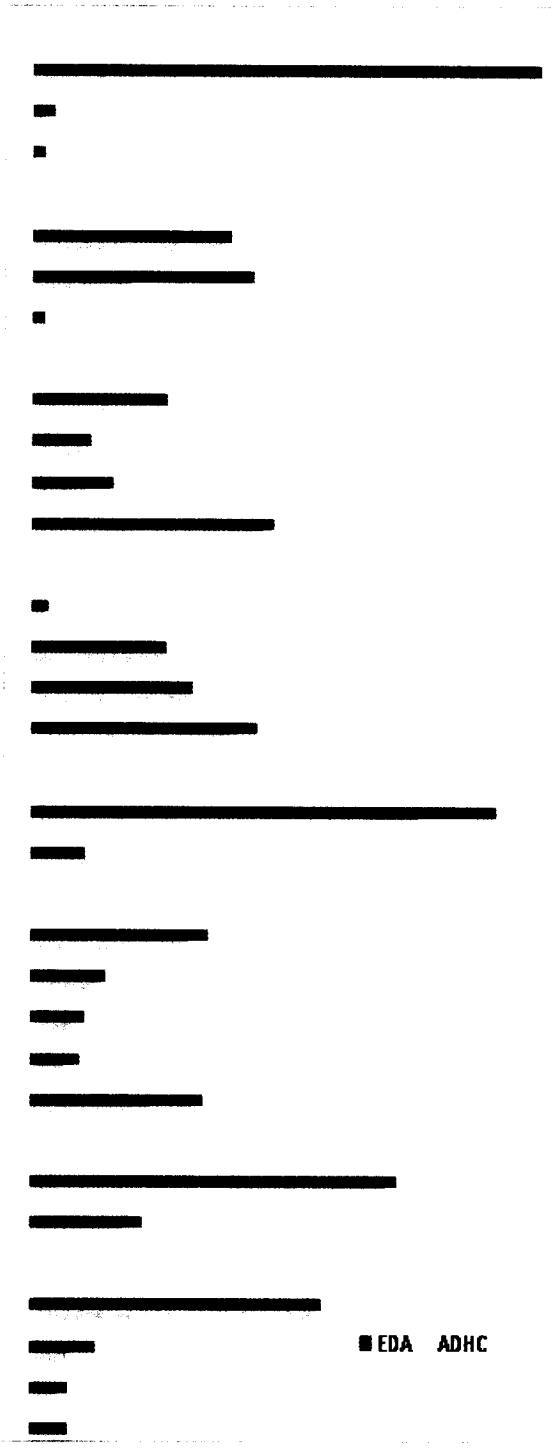
The survey provides a generally positive picture of ADHC in Louisiana. ADHC recipients generally chose the center they attend (76.8%). Nearly 2/3 are involved in planning the services they receive and almost all (97%) state that the services they receive include the things that are important to them. ADHC recipients have positive impressions of the Center that they attend and the staff employed by the center. A large majority (95%) report that center staff complete tasks the way the recipients like to have them done. They do not report incidents of poor care or abuse. Only about 1% report disrespectful treatment, and even fewer report injury at the hands of an ADHC worker.

Health Indicators. Potential areas for quality improvement also came to light in the survey. ADHC participants underuse medical preventive services. For example, only about half (53%) report an eye exam in the past year and nearly as many (44%) report it had been more than five years since they have seen a dentist. Just over 70% of female respondents have ever had a Pap smear while a somewhat smaller number of male respondents (66%) have ever had the prostate specific antigen test (PSA). Participants also seem to underuse assistive technology, with 85% reporting that a home modification or piece of equipment would make their lives easier and 15% reporting that center staff have talked with them about such adaptations. In instances where ADHC staff did discuss adaptations, nearly 60% were able to follow through and acquire the needed modification or equipment. Obesity is also an issue, with 30% of participants reporting a Body Mass Index (BMI) score that indicates they are overweight, and 37% reporting scores in the obese range. This finding suggests there could be benefit in improving education and services in the area of nutrition, weight management, and exercise.

Table #7 below illustrates that there is very little difference between the ADHC waiver and the Elderly and Disabled (EDA) waiver on those consumer survey items that relate to health and preventive services.

TABLE #7 – Consumer Survey Findings

	EDA	ADHC
Last visited a doctor		
Within the past year	94%	98%
Within past two years	4%	2%
Over 2 years\not sure	2%	0%
Eyes examined		
Within the past year	37%	53%
Within past two years	41%	18%
Over 2 years\not sure	2%	26%
Visited a dentist		
Within the past year	25%	29%
Within past two years	11%	15%
Within the past 5 year	15%	10%
More than 5 years	45%	43%
BMI		
Underweight	3%	2%
Normal	25%	31%
Overweight	30%	30%
Obese	42%	37%
Pap Ever		
Yes	86%	72%
No	10%	13%
Last Pap		
Within the past year	33%	29%
Within past two years	14%	14%
Within past three years	10%	10%
Within the past 5 year	9%	6%
More than 5 years	32%	22%
PSA Ever		
Yes	68%	66%
No	21%	17%
Last PSA		
Within the past year	54%	55%
Within past two years	12%	7%
Within past three years	7%	5%
More than 5 years	7%	10%



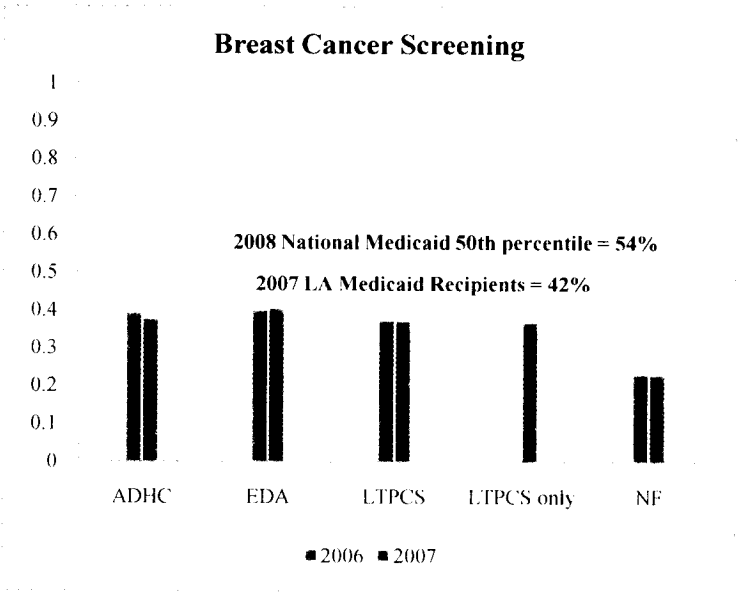

~~~
~~~

Consumer survey findings are reinforced by analysis of claims data. For instance, using the national Health Effectiveness Data and Information Set (HEDIS) measure for breast cancer screening (which looks at the percentage of women age 40-69 who receive screening in a two year period, Table #8), Louisiana's community-based long-term care programs all show similar outcomes in percentage of participants receiving screening. All community-based programs outperform nursing homes, but recipients of Medicaid-funded long-term care in Louisiana have lower rates of screening than the general Medicaid population.

TABLE #8 – Breast Cancer Screening

Breast Cancer Screening (HEDIS-BCS): percentage of women age 40-69 who had a mammogram within the previous 2 years (80% covered by Medicare & 20% covered by Medicaid – cross over claims are used for this measure)

Breast Cancer Screening	2006		2007	
	N	%	N	%
ADHC	105	39%	120	38%
EDA	463	40%	469	40%
LTPCS	1,541	37%	2,369	37%
LTPCS only	n/a		1,780	37%
NF	2,364	23%	2,461	23%



Datasource: 2008 Benchmarks from NCQA Report

~~~

The apparent underuse of screening and preventive services may reflect population differences – e.g., older adults may be less willing to seek these services. The fact that this finding is applicable across programs suggests the potential for a broad-based quality improvement effort, one that goes beyond ADHC providers to also include support coordinators, primary care providers, and system-level interventions that integrate medical and long-term care.
~~~

CONCLUSION

RECOMMENDATIONS

The following recommendations were approved by consensus or majority of Advisory Council members.

Licensing (Scope of Service)

1) DHH should revise the licensing requirements for ADHC to accommodate the recommendations in this report.
2) In order to avoid the need for dual licenses, there should be a single ADHC license with a core set of standards, plus additional standards for one or more service "tiers" on a continuum from social to medical models.
3) Licensing standards should support the building of a private pay base for ADHC.

Rate Methodology

1) Consistent with changes in licensing, the Department should develop and implement a new rate methodology for ADHC.
2) Consider whether participant acuity/need should be a factor in any new rate methodology developed by the Department.
3) The Department should either recognize transportation time as participant time spent in the ADHC program (i.e., as time "billable" by the ADHC), or consider a separate rate or payment for transportation provided by ADHCs.
4) The Department should explore the feasibility of Pay for Performance.

Payment Methodology

1) The Department should eliminate the "5-hour rule" that requires a participant attend a center for 5 hours in order for the provider to receive reimbursement.
2) The unit of payment for ADHC services should be no less than 15 minutes and no more than one hour.
3) In moving to a one hour unit of payment, the Department should consider whether a maximum number of hours (per day, week or month) should be implemented.
4) Transportation should either be accounted for in the hours billable by an ADHC or be paid for under a separate rate or method (see above).

Access

1. To the extent feasible, implement waiting list prioritization and other policies to better assure that individuals on the list will accept ADHC services when offered.
    - Consider giving priority to individuals being discharged from a hospital or who have been discharged within the previous 30 days.
    - Implement wait list management strategies that would allow information about individuals requesting services in all areas of the state to be collected and retained, but that would not waste administrative time and resources in making offers to individuals who have no ADHC provider in their area.
    - Improve information and training of call center staff and support coordinators to assure that individuals asking to be placed on the registry have a clear understanding of how ADHC services are delivered, what they consist of, the areas in which ADHC is and is not available, and of other LTC services available to waiver participants.
    - Explore feasibility, benefits and barriers, of maintaining regional wait lists for ADHC waiver services.
2. In addition to improvements in waiting list policy & management, further evaluate, simplify, and improve access procedures to reduce or eliminate procedural barriers to filling available slots on a consistent basis. Include consideration of regional access models (such as the Region 2 Single Point of Entry pilot) in this evaluation.
3. Encourage development of ADHC Centers in areas where they do not exist.
    - Evaluate barriers in licensing regulations which make it difficult to operate centers in areas with a small population base.
    - Use Title 3 (Older Americans Act funds) to support ADHCs in underserved areas.
    - Increase waiver slots commensurate with program expansion to underserved areas.

SFY 2009-2010 RATE AND FACILITY NEED REVIEW

In addition to mandating the review and independent evaluation provided above, HCR 190 requires that DHH

1) Reconsider the rate reduction proposed for Fiscal Year 2009-2010, and
2) Implement a facility need review process for ADHC centers seeking to enroll in Medicaid

Proposed Rate Reduction

Though reductions to provider rates were discussed during the 2009 Regular Session, no cuts were passed or implemented. As discussed in another section of this report, costs associated with support coordination were removed from the ADHC rate in January, 2009 reducing the daily rate from $65.45 to $60.79. A subsequent rebasing of rates, which went into effect July 1, 2009, brought the daily rate back up to $64.40. This is consistent with the national average reported by AAHSA of $64.00, inclusive of reimbursement for transportation.

Facility Need Review (FNR)
DHH published the Notice of Intent to establish rules for ADHC facility need review in September, 2009. The proposed rule requires submission of an FNR application, which must include data and other evidence demonstrating the probability of serious, adverse consequences to recipients' ability to access adult day health care if the applicant is not allowed to be licensed. In reviewing the application, DHH may consider factors such as the number of ADHC providers in the same geographic location serving the same population, and "allegations involving issues of access to health care and services." The FNR application must be approved before the applicant can seek licensure. The final rule for ADHC FNR should be published in the February 20, 2010 Louisiana Register.

NEXT STEPS

The DHH Office of Aging and Adult Services will convene stakeholders, including members of the Advisory Council, in implementing the recommendations in this report. It is anticipated that there will be at least three work groups to implement (1) licensing recommendations, (2) rate and payment recommendations, and (3) recommendations to streamline and improve program access.

BIBLIOGRAPHY

Department of Health and Human Services. Office of Disability, Aging and Long-Term Care Policy. *Regulatory Review of Adult Day Services: Final Report.* By Kristin Siebenaler, Janet O'Keefe, Christine O'Keefe, David Brown, and Beth Koetse. 26 Aug. 2005. Web. 03 Feb. 2010. <http://aspe.hhs.gov/daltcp/reports/adultday.htm>.

Lucas, Judith A., Nancy S. Rosato, Jin A. Lee, and Sandra Howell-White. *Adult Day Health Services: A Review of the Literature.* Rep. Rutgers, NJ: Rutgers Center for State Health Policy, 2002. Print.

Murphy, M. B. *Standards & Guidelines for Adult Day Services.* McLean, Virginia: National Adult Day Services Association, 1997. Print

The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs. Rep. MetLife Mature Market Institute, 2009. Web. 02 Feb. 2010. http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf

H.R. 3043, The Medicare Adult Day Services Act. 111th Cong., <Http://www.thomas.gov/cgibin/query/D?c111:1:./temp/~c111kUb6PD:: >(2009) (02/02/2010)

Aging Services Standards Manuals Washington, DC Commission on Accreditation of Rehabilitation Facilities--Continuing Care Accreditation Commission. (CARF-CCAC),2009. Print

ENROLLED

Regular Session, 2009

HOUSE CONCURRENT RESOLUTION NO. 190

BY REPRESENTATIVES BARROW, HARDY, MICHAEL JACKSON, AND PATRICIA SMITH AND SENATORS BROOME AND GUILLORY

A CONCURRENT RESOLUTION

To direct the Department of Health and Hospitals to reconsider proposed rate cuts, implement a facility need review process, to conduct an evaluation of adult day health care reimbursement and services in Louisiana and create a method for increasing the reimbursement rate to adult day health care providers, to create an advisory council to help the department implement this Resolution, to study the feasibility and advisability of expanding the adult day health care waiver services program, and to report on these matters at least thirty days prior to the 2010 Regular Session of the Legislature.

WHEREAS, the adult day health care program is the only community-based nursing program option in the overall long-term care system; and

WHEREAS, both the elderly and disabled populations benefit when they receive services tailored to meet the level of care they require; and

WHEREAS, in spite of the fact that more persons are now receiving publicly funded adult day health care services than ever before, the service is still unavailable in many areas of the state; and

WHEREAS, the Department of Health and Hospitals has expanded the number of persons eligible to receive adult day health care services in an effort to make the services more available, thereby increasing the customer base for providers; and

WHEREAS, many adult day health care providers are experiencing financial difficulties which threaten the viability and availability of this important service.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby direct the Department of Health and Hospitals to reconsider the rate reduction proposed for

Fiscal Year 2009-2010 and attempt to find a means of financing to rebase the adult day health care waiver provider reimbursement rate.

BE IT FURTHER RESOLVED that the Department of Health and Hospitals shall implement a facility need review process for adult day health care centers seeking to enroll as Medicaid providers of adult day health care.

BE IT FURTHER RESOLVED that the office of aging and adult services shall conduct an independent review of the adult day health care program which shall include but not be limited to a study of the rate methodology, reimbursement methodology, scope of service, and client outcomes, including a review of the five-hour rule which requires a client physically to remain in the facility for five hours in order for the provider to receive reimbursement.

BE IT FURTHER RESOLVED that the office of aging and adult services shall examine the processes by which individuals access or apply for adult day health care services and take such steps as possible, consistent with best practices and the Centers for Medicare and Medicaid Services (CMS) requirements, to simplify those processes.

BE IT FURTHER RESOLVED that the Department of Health and Hospitals shall convene an adult day health care advisory council for the purpose of providing input and feedback to the department in implementing this Resolution. The sixteen members of the advisory council shall be:

(1) The assistant secretary of the office of aging and adult services or his designee.

(2) The director of Medicaid or his designee.

(3) The director of the health standards section of Medicaid or his designee.

(4) The director of the rate and audit review section of Medicaid or his designee.

(5) A member of the quality improvement section of the office of aging and adult services.

(6) The president of the Louisiana Adult Day Services Association or his designee.

(7) One representative of a free-standing adult day health care center appointed by the Louisiana Adult Day Services Association.

(8) One representative of a hospital-affiliated adult day health care center appointed by the Louisiana Adult Day Services Association.

(9) One representative of an adult day health care center that is not affiliated with the Louisiana Adult Day Services Association, appointed by the office of aging and adult services.

(10) One representative of the Advocacy Center.

(11) One representative of the American Association of Retired Persons.

(12) The executive director of the Governor's Office of Elderly Affairs or his designee.

(13) One medical professional specializing in geriatric care appointed by the Louisiana Geriatric Society.

(14) One representative of the Alzheimer's Association.

(15) The governor's advisor on health care policy.

BE IT FURTHER RESOLVED that the adult day health care advisory council shall hold its first meeting no later than August 14, 2009, and shall meet thereafter for a minimum of six meetings in order to satisfy the requirements set forth in this Resolution.

BE IT FURTHER RESOLVED that the term of the adult day health care advisory council shall end upon submission of the report required by this Resolution.

BE IT FURTHER RESOLVED that the Department of Health and Hospitals shall prepare a report on implementation of this Resolution and the results of the reviews and evaluations conducted pursuant to this Resolution. The report shall be transmitted to the House and Senate committees on health and welfare at least thirty days prior to the convening of the 2010 Regular Session of the Legislature.

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

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE