Bobby Jindal
GOVERNOR

Bruce D. Greenstein
SECRETARY

State of Louisiana

Department of Health and Hospitals

Office of the Secretary

April 6, 2011

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

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

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

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

The Honorable Jim Fannin, Chairman
House Appropriations Committee
Louisiana State House of Representatives
P.O. Box 44486, Capitol Station
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The Honorable Michael J. Michot, Chairman
Senate Finance Committee
Louisiana State Senate
P.O. Box 94183, Capitol Station
Baton Rouge, LA 70804-9183

Dear President Chaisson, Speaker Tucker, and Honorable Chairs:

In response to House Concurrent Resolution No. 234 (HCR 234) of the 2010 Regular Session, the Louisiana Department of Health and Hospitals (DHH) submits the enclosed report. The resolution requests that DHH create a task force to study funding options for services to persons with disabilities and the elderly and to report findings and recommendations of the study to the House Committee on Health and Welfare, the Senate Committee on Health and Welfare, the House Committee on Appropriations, and the Senate Committee on Finance. R.S. 24:772 also requires that the report be submitted to the President of the Senate and the Speaker of the House.

DHH is available to discuss the enclosed report and recommendations with you at your convenience. Please contact Julia Kenny, assistant secretary for the office for citizens with developmental disabilities, at (225) 342-0095 with any questions or comments you may have.

Sincerely,

Bruce D. Greenstein
Secretary

Enclosures

Cc: The Honorable Members of the House Health and Welfare Committee
The Honorable Members of the Senate Health and Welfare Committee
The Honorable Members of the House Appropriations Committee
The Honorable Members of the Senate Finance Committee
David R. Poynter Legislative Research Library

DEPARTMENT OF HEALTH AND HOSPITALS

FUNDING OPTIONS FOR SERVICES FOR PERSONS WITH DISABILITIES AND THE ELDERLY

REPORT PREPARED IN RESPONSE TO HCR 234 OF THE 2010 REGULAR SESSION

APRIL 2011

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EXECUTIVE SUMMARY

House Concurrent Resolution (HCR) 234 of the 2010 Regular Session, co-authored by Representative Scott M. Simon and Senator John A. Alario, charges the Department of Health and Hospitals (DHH) with creating a task force "which shall study funding options for services to persons with disabilities and the elderly and to report findings and recommendations of the study to the House Committee on Health and Welfare, the Senate Committee on Health and Welfare, the House Committee on Appropriations, and the Senate Committee on Finance." In response to HCR 234, DHH convened a task force comprised of the following members:

Jeanne Abadie, Advocacy Center

Laura Brackin, Ph.D., Executive Director, The Arc of Louisiana

Randy Davidson, DHH/Medicaid Waiver Assistance & Compliance Section Chief

Joshua Hardy, DHH/Office for Citizens with Developmental Disabilities

Julia Kenny, Assistant Secretary, DHH/Office for Citizens with Developmental Disabilities

Barry Meyer, Executive Director, Arc of Baton Rouge

Robin Wagner, Deputy Assistant Secretary, DHH/Office of Aging and Adult Services

Beth Jordan, Facilitator, DHH/Office for Citizens with Developmental Disabilities

The task force held several meetings where each member participated in presentation of researched funding strategies utilized by other states. In addition, the task force produced several innovative revenue generating options for the legislature to consider. This report examines the following options for the generation of revenue: Individual Voluntary Contributions, Local Contributions, Louisiana Lottery, Public Private Partnerships, State Self-Generated Funds, Prepaid Developmental Disabilities Savings Program, and Other (Cash Redemption/Refund Program for Beverage Container Recycling).

To address funding of services for individuals with disabilities and those who are elderly, a more thorough economic analysis should be conducted on the specific options that the Louisiana Legislature would like to further pursue. Additionally, further investigation is needed to ensure compliance with Centers for Medicare & Medicaid Services (CMS) regulations and other state and federal laws.

THE NEED FOR NEW SOURCES OF REVENUE IN MEDICAID

The Department of Health and Hospitals' mission is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the state of Louisiana. This includes individuals with disabilities and those who are elderly, who are in need of critical services that enable them to live healthy, independent, and productive lives. The majority of funding to support the services provided to individuals with disabilities and the elderly is a mixture of state and federal funds through the federal Medicaid program. Changes in federal Medicaid match requirements, increased eligibility (resulting in a 4.4 percent increase in the number of eligible people joining the Medicaid rolls since last year), and an overutilization of Medicaid services have created a strain on the Medicaid budget, thus prompting a need to reevaluate how Louisiana currently funds Medicaid services.

Over the past few years DHH has taken several major steps in a comprehensive plan designed to cut unnecessary expenditures and spend existing funds more efficiently. The Department is constantly seeking better ways to ensure that individuals in vulnerable populations get the care they need and to do so by living within the state's means. Action steps taken thus far include, but are not limited to:

- Implementing Resource Allocation models to objectively assess an individual's specific needs and allocate services based on need;
- Transitioning individuals from high cost state-operated large Intermediate Care Facilities for Developmental Disabilities (ICF/DD) to more appropriate and less costly ICF/DD services or community based waiver programs;
- Privatizing state-operated services; and
- Closing high cost state-operated institutions, transferring property to other state departments, and leasing or selling unused property.

RESOURCE ALLOCATION

Implementation of a Resource Allocation System was mandated by the Louisiana Legislature during the 2008 regular legislative session through HR 190 and SR 180 and again in 2010 when Act 305 was signed into law. Even without these mandates, it has been recognized that a system that matches need and resources is necessary for the sustainability of the home and community-based service programs. Implementation of this system is consistent with national standards of practice. By imbedding the

Resource Allocation System within each office's person-driven planning process, OCDD and OAAS are maintaining a responsive, flexible system that allows for unique individual planning and support differences.

The Resource Allocation System establishes a balance such that fiscal savings are recognized supporting the sustainability of community-based programs; acknowledges the uniqueness of each recipient and the challenges of developing any model/system that can work for everyone; and allows for flexibility when appropriate with a systematic review process and quality monitoring system. Both offices will conduct ongoing analysis of the fiscal and programmatic elements of the system to determine the impact of implementation and the any need for modifications. During the initial implementation this past fiscal year, OCDD provided an allowance for recipients to "phase-in" to their appropriate resource allocation level over time, and conducted conservative reviews and negotiations with recipients in exploring options that work for each of them. Nonetheless, OCDD still averaged a savings of $17,100.00 per recipient per year when compared to the previous fiscal year costs. This resulted in a plan savings of $6 million in SFY 10 with a projected savings of $21 million in SFY 11. In SFY 2010, OAAS reduced the average costs for community-based programs by 10% to 20% without seeing any increase in admissions from these programs in to nursing homes. Along with other programmatic changes, the office was able to serve an additional 2,000 individuals while reducing spending by about $17 million.

SYSTEMS REBALANCING

Louisiana's Medicaid long-term care services have historically been among the most institutionally biased in the nation. Although the state began the process of "rebalancing" relatively late compared to other states, considerable progress has been made since 2000 when Louisiana ranked 49th in percentage of spending for community-based vs. institutional long-term care for people with disabilities and the elderly. Although many strides have been made, Louisiana ranks highest in the nation for the use of Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) with only 56 percent of individuals with development al disabilities receiving community based services compared to the national average of nearly 84 percent. Additionally, Louisiana ranks high in the number of nursing home beds and has a 72 percent nursing home occupancy rate, one of the lowest in the nation.

In 2010, OAAS's home and community-based programs cost $8,755 less per person than Louisiana's Medicaid nursing home care. Home and community based services through the New Opportunities Waiver Program is a third of the cost for publically operated ICF/DD services. With Resource allocation, new recipients in the NOW are averaging $46,000 per year compared to $58,000 for private ICF/DD

services. Home and community based services through both offices are a lower cost and have demonstrated better quality outcomes for the individuals served.

The offices are also moving away from functioning as providers through downsizing, consolidation and privatization of services. OAAS will no longer operate the John J. Hainkel Home after April 2011 and OCDD will be down to three large ICF/DD facilities by the end of the fiscal year. In 2010, OCDD ceased operation of public community residential programs, including waiver services and 30 ICF/DDs ICF/DD closures resulted in annual savings ranging from $62,000 up to $77,000 per persons.

The U.S. Supreme Court's 1999 decision in *Olmstead v. L.C.* noted that "confinement in an institution severely diminishes the everyday life activities of individuals – including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." The ruling found that unnecessary institutionalization could be a form of discrimination under the Americans with Disabilities Act (ADA). Louisiana was one of the first states to be sued under *Olmstead.* The settlement agreement in *Barthelemy vs. Louisiana Department of Health,* which expired in December 2010, mandated the implementation of the Long-Term Personal Care Services program as a Medicaid state plan "entitlement," and prior to its expiration determined many features of the system of Medicaid-funded home and community based services in Louisiana.. Louisiana remains at risk for future *Olmstead* related suits. The U.S. Department of Justice has become more actively involved in litigation and enforcement related to deinstitutionalization and long-term care during the new administration. They have intervened in, or participated as an amicus or an interested party in Olmstead litigation in Connecticut, Florida, Georgia, Illinois, New York, North Carolina and Virginia, and have ongoing investigations or litigation with an Olmstead component in California, Iowa, Maryland, Nebraska, New Jersey, Oregon, Pennsylvania, Texas and the District of Columbia. The Georgia settlement is very aggressive by prohibiting institutional admissions beginning the summer of 2011 with the closure of all institutions by 2015.

These actions have resulted in cost savings of over $35 million for SFY 09-10. It is anticipated that the cost savings for the current fiscal year (SFY 10-11) will meet or exceed the cost savings of SFY 09-10. Despite successful efforts to eliminate unnecessary expenditures, use current funds more efficiently by privatizing state operated services and downsizing costly institutional care, and the implementation of a methodology to fairly allocate limited resources based on a person's acuity or level of disability in a manner that also supports the individual's preferences and goals, the state still has significant waiting lists for home- and community-based services. There are approximately 9,400 individuals with disabilities who are on the registry for services through DHH/Office of Citizens with Developmental Disabilities

(OCDD) and another 18,000 individuals who are elderly awaiting services through DHH/Office and Aging and Adult Services (OAAS). The large number of individuals waiting for services (over 27,000) is an indication that continued focus on shifting resources to less costly community-based services is necessary along with recognizing that the current resources available to Medicaid budget is not sufficient to meet the needs of Louisianians with disabilities and those who are elderly. According to a recent report by the Administration on Aging, Louisiana has one of the highest poverty rates for person over the age of 65. Therefore, it is critical for DHH to generate new sources of revenue in order to meet this need as well as continuing to rebalance resources to meet the needs of more citizens

In addition to systems rebalancing, the HCR 234 task force has identified the following possible new sources of revenue in addition to current efforts to create a sustainable delivery system:

- Individual Voluntary Contributions,
- Local Contributions,
- Louisiana Lottery,
- Public Private Partnerships,
- State Self-Generated Funds,
- Prepaid Developmental Disability Savings Programs,
- Other (Cash Redemption/Refund Program for Beverage Container Recycling)
- Resource Allocation, and
- Systems Rebalancing.

INDIVIDUAL VOLUNTARY CONTRIBUTIONS

An Individual Voluntary Contribution (IVC) is an election made by an individual to designate a specific amount of his/her money for the sole use of the state.

According to Giving USA, contributions in the United States exceeded $300 billion in 2008, of which, 75% ($225 billion) came from individuals. In addition, studies show that those in need, often give the most. According the US Labor Statistics, in 2009 the lowest income group (earning on average $10,531) donated 4.3% of their income as compared to the highest income bracket at 2.1%.

State issued forms, which include a voluntary check off for donations, afford individual citizens the opportunity to give money where it is most needed. There are several options for notifying individuals of opportunities to make an Individual Voluntary Contribution, which include the following:

1. **Tax returns** – A voluntary check off box on state tax return forms would allow individuals the option to donate all or a portion of their tax refund. The money would go into a Disability and Elderly Trust Fund, which could then be used as state match to draw down additional federal dollars.
2. **State issued license forms** – A voluntary check off box would allow individuals an opportunity to make a donation whenever they register for a state issued license (drivers, motor vehicle, hunting, fishing, etc.).

LOCAL CONTRIBUTIONS

A Local Contribution is money that may be:

- **Funds expended by a governmental entity other than the State for Medicaid type services,**
- **Funds donated to the State Medicaid Program, or**
- **Supplemental funding of Medicaid rates.**

Appendix A provides the relevant citations of the Code of Federal Regulations which provide for the use of local funds for Medicaid match.

1. **Expenditures of Local Public Funds**

Medicaid regulations provide for the certification of funds other than State General Funds as matching funds according to Federal Regulations (42 CFR 433.51) for the Medicaid program. A local agency (for example, a parish, District, Authority, or municipal government) does not have the authority to "certify" funds. The agency must provide services or activities that are reimbursable under the Medicaid State plan as approved by CMS; the local agency must be able to demonstrate expenditures for allowable eligible individuals or activities. The state is then able to "draw down" federal funds for these expenditures. The expenditure of allowable sources of funds for allowable services to Medicaid eligibles or for administrative activities is then "certified."

Public funds expended for Medicaid recipients and services clearly are the main source of allowable matching funds, including those from organizations or entities that have taxation authority (which also appears to include municipalities in addition to the State and parishes) or entities that receive tax funds and provide Medicaid allowable services using those funds (e.g., Human Services Districts and Authorities). Medicaid regulations require that state funds, as opposed to local funds, pay for at least 40%

of the total State required share of Medicaid. Another key provision is the requirement that if local funds provide for matching federal funds, a lack of local funds cannot impact services.

Although local funds from non-state public entities may clearly be used as a portion of the required State share of Medicaid, federal regulations require that the use of local funds cannot undermine the basic Medicaid tenet of providing comparable services across the state. This provision must be expressly waived by the Secretary of Health and Human Services as part of the approval of the Medicaid State plan or other Medicaid waivers for services to differ substantially from one region of the state to another.

Consequently, it follows that an equalization formula similar to the Minimum Foundation Formula (MFP) might be necessary to accommodate any potential adverse impact to a particular political subdivision that did not have the capacity to provide local funds.

2. Donations

Donations are acceptable with some limitations. The main caveat is that the source of the donation cannot directly benefit from the donation. This means that if an agency makes a donation, the agency cannot accrue FFP (Federal Financial Participation) directly for making the donation. Donations become part of the general pool of funds used as match for claims submitted by the Single State Medicaid Agency to CMS.

Federal regulations found in 42 CFR 433.54 describe what are considered "bona fide donations." For private funds to serve as match, they must be converted to public funds via donation (i.e., they need to come under the control of a governmental entity). Individuals or organizations can make donations, but these donations must be made to a public agency.

The federal regulations are intended to prevent donations being handled on a "quid pro quo" basis - that is, if agency *X* donates funds, the flow back of Medicaid dollars cannot be solely back to agency *X*.

3. Rate Supplementation

Federal regulations mandate that providers must "...accept as payment in full the amount paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual."

If the state or parish supplements the payment rates and if the payment rates established by Medicaid were changed to reflect these costs, the FFP (Federal Financial Participation) could be claimed. Some states have payment rates for home and community-based services that are negotiated rates based on an allowable-costs manual. Using this approach, payments for services can be individualized and the actual cost of the service is eligible for FFP. In states with such systems, the allocation of state funds to the counties for community services programs is made by the state. The counties are required to add a certain

percentage to this pool of funds (called "required county match") and can put in more if the county wishes to do so (called "overmatch"), thus increasing the pool. These funds may be used as match for Medicaid Home and Community-Based Services (HCBS) allowable services to eligible individuals because the rates for services are individualized rather than set. The additional funding that counties put into the system easily becomes part of the overall claim for FFP.

Examples of potential use of local funds for Medicaid match might be:

- United Way or other private funds that currently go to waiver-type services for Medicaid eligibles are certified to get Medicaid Match.
- Local millages (or any other non-state funds that go to waiver type services) – Following demonstration of proof retrospectively by the entity that the money was spent, the state gets those funds certified and pull down the corresponding match.

LOUISIANA LOTTERY

Several states use either all or a portion of their lottery revenue to support services for individuals with disabilities and those who are elderly. Louisiana currently uses lottery revenue to fund much needed educational services. However, there are several options which build upon the existing lottery system and therefore would not/should not be to the detriment of the state's educational system.

1. **Lottery Vending Machines** – Use lottery vending machines to sell scratch off tickets. All proceeds from these specific machines would be dedicated to services for individuals with disabilities and those who are elderly.
2. **Special lottery ticket** – Develop a special lottery ticket with revenue dedicated to services for individuals with disabilities and those who are elderly. Several disability-related organizations have expressed interest in pushing ticket sales with proceeds from the special ticket benefiting much needed community-based services.
3. **Surcharge on winnings** – Place a surcharge on winnings that exceed a certain amount.

PUBLIC PRIVATE PARTNERSHIPS

Local governmental entities currently provide services to Louisiana citizens with developmental disabilities using state and local funds to cover the cost of these services. Services that are not covered by Medicaid are not available for Medicaid federal matching funds. However, through a public private partnership agreement a private hospital may choose to provide these services to those same recipients, relieving the local entity from providing the services and freeing up the state and local funds that would

have paid for those services. Under this project, these freed up funds would be transferred to DHH. The Department can use these funds to draw down federal Medicaid funds to increase the amount paid to the hospital through the Hospital Upper Payment Limit (UPL) program. Officially, there is no link between the increase in the UPL payment to the hospital and the hospital providing the services. The local entity would work with the hospital to ensure that the services for which they assume responsibility are provided sufficiently and at the same level of quality provided prior to this arrangement.

The state plan has already been approved by CMS for this type of program, and DHH is currently working with the hospital industry to provide critical services by accelerating the Upper Payment Limit (UPL) program. Since early December 2010, sixteen hospitals that have entered into such agreements have received $27 million in supplemental payments. DHH has been able to retain some of the initial funding, which can now be reallocated to other programs.

This same model could be extended to provide services for individuals with disabilities and those who are elderly. Providers would enter into Cooperative Endeavor Agreements with DHH requiring coordination between DHH and/or the public entity previously responsible for these services and private hospitals to oversee the provision of services to ensure required standards. Agreements would be coordinated with participating hospitals and negotiations conducted on how each party would benefit under the collaborative. An Intergovernmental Transfer (IGT) of funds to DHH would be required prior to UPL/DSH (Upper Payment Limit/Disproportionate Share Hospital) payment being made.

STATE SELF-GENERATED FUNDS

Providers of home and community-based services, such as waiver services, are already required to purchase or obtain certain services, such training for direct service workers, background checks, and billing software. DHH could purchase the required services at a lower cost due to the volume of the purchase. Providers could purchase the services through the state (as they currently do with background checks) and DHH could use the funds as a match for pulling down additional federal funds. In addition, as lagniappe, these valuable services could reduce costs to providers and have other tangible benefits such as more quality and consistency among provider organizations statewide. Specific examples are noted below:

1. **College of Direct Support Professionals** is an online curriculum for training direct service workers, which would facilitate quality and consistency statewide. There would be low or no administrative cost involved for implementation.

2. **Talentel** is screening software for direct service workers (DSW). DHH could use Talentel in both state settings and community-based settings to provide better matching and reduce the high turnover rates of direct service workers. This would result in saving money for the providers and generating a better pool of direct service workers. DHH could charge a fee per DSW applicant (that would be added back to rates at pennies per unit) to providers including DHHthemselves. Collected fees could then be used as match to pull down additional federal funds generating the same ROI (Return on Investment) as a provider fee without being a provider fee. An amendment to existing waivers would not be required as there is a straight payment for services to the state, such as background check fee and licensing fee.
3. **Fleet Management/Monitoring System** would help track services and enable providers to increase efficiency, improve driver safety, and reduce cost; it would also provide visibility into the usage patterns of drivers after-hours and in unauthorized areas. The system could reduce operation costs and limit operating risk.
4. **Other training (Portico)** – DHH has already purchasing online training for employees through Portico. The contract could be expanded to allow DHH access to the online training. The Office would then charge themselves and the HCBS providers for on-line training (driving safety, HIPAA, and six other web based courses). Online training would benefit providers as it is more cost effective than traditional face-to-face training. In addition, online training allows for consistency in training across the state, which would improve overall quality of services. The funds received for these trainings could be certified as state funds and then used as match for Medicaid.
5. **Call Based Billing** (MITC Software) provides real time accumulation of billing/call based billing. DHH could purchase the billing services at a lower rate due to volume. Providers are currently paying for billing services; however, when purchased through the state, DHH could use the funds to draw down additional Medicaid funds.

PREPAID DEVELOPMENTAL DISABILITIES SAVINGS PROGRAM

Louisiana's Prepaid College Tuition Program, Student Tuition Assistance and Revenue Trust Program (START), is "an innovative college savings plan designed to help families contend with the growing costs of educating their children after high school." The START program has been a huge success and is currently rated number one in the country. Approximately 39,400 plans have been sold as of December 2010, demonstrating that parents are actively seeking to plan for the future of their children. However,

parents of children with developmental disabilities are unable to access this program to plan and save for their children's future because the START is limited to postsecondary education, which thus excludes individuals who do not have the capacity for postsecondary education.

A Prepaid Developmental Disabilities Savings Plan, similar to the START model, would allow parents of individuals with disabilities to plan and save for their children's future. The money in the account could be used in those few critical years after exiting high school to purchase training and services. Services could include: on-the-job training, job coaching, independent living skills, or other services designed to assist the child in living a productive and independent life.

The Prepaid Developmental Disabilities Savings Plan could fill an important gap in services for students with developmental disabilities who have exited the school system and are placed on a waiting list for services. Parents of children with disabilities should be allowed to save for the future of their children with disabilities, just as they are able to save for the future of their children without disabilities. Not only would this program provide options for families, in turn it could help to alleviate some of the financial burden on the state, as individuals exercise more personal responsibility.

OTHER: INSTITUTE A CASH REDEEMABLE/REFUND VALUE PROGRAM FOR BEVERAGE CONTAINER RECYCLING

Act 185 of the 1989 Louisiana Legislature found that the removal of certain materials from the solid waste stream going into landfills currently being utilized for the disposal of solid waste in Louisiana is necessary and benefits all citizens of the state. Furthermore, the identification of markets and distribution networks for recyclable or recycled materials is a necessary prerequisite to the orderly development of statewide recycling programs. The legislature further found that the state must demonstrate its commitment to proper solid waste management by establishing source separation and recycling programs, and by encouraging market development through the purchase of recycled products by the state government[i].

Recycling laws have proven not only to have a positive effect on the environment but also significant economic benefits. For example, results from a 2010 Southeast Recycling Development Council study found that for every 20% of solid waste recycled, the state could see an additional 1,200 jobs, adding roughly $58.5 million to the economy in personal income and an estimated $2.6 million in state tax revenues[ii]. Additionally, a recent study commissioned by *Keep Louisiana Beautiful* estimated the direct economic impact of paying to have litter collected and disposed costs local and state government to be

$40 million per year[iii]. It is in the best interest of the state to consider recycling incentive programs as an indispensable component of litter abatement plans.

House Bill 760 of the 2010 Regular Session urged to legislature to consider adopting the Louisiana Beverage Container Law. It proposed instituting a bottle deposit to be placed on aluminum and glass beverage containers. The Cash Redeemable/Refund Value (CRV) is somewhat different than a bottle deposit law. California, the only state to use a CRV program, remains number one in the nation in the total quantity of bottles and cans recycled. Under existing law, the California Beverage Container Recycling and Litter Reduction Act, every beverage container sold or offered for sale in the state is required to have a minimum refund value. A distributor is required to pay a redemption payment for every beverage container sold or offered for sale in the state to the Department of Conservation and the department is required to deposit those amounts in the California Beverage Container Recycling Fund. The money in the fund is continuously appropriated to the department for the payment of refund values and processing fees. A violation of the act is a crime[iv].

In 2009, California beverage distributors sold 8.2 billion plastic bottles (#1 PET plastic), 9.2 billion aluminum beverage containers, and 3.1 billion glass bottles. Of these beverage containers, consumers recycled 6 billion plastic bottles, 8.3 billion aluminum cans, and 2.5 billion glass bottles. The recycling rate for was 91% for aluminum cans, 73% for plastic bottles, and 80% for glass containers[v]. Given these sales and U.S. Census population estimates[vi], it is possible to estimate the fiscal impact of instituting a CRV program on the sale of beverage containers in the State. Assuming that consumer behavior and preference are constant (i.e., the Louisiana consumer realizes the same utility from beverage consumption as does the California consumer), it can be estimated that in 2009 Louisianans purchased approximately 1.1 billion aluminum cans, 994 million #1 plastic bottles, and 381 million glass containers. Applying the current lowest cash redemption value in California of $0.05 to the estimated sales of beverage containers yields approximately $124.6 million in CRV and generates more than $4.9 million in state sales tax revenues.

A thorough economic analysis should be conducted, as these estimates are based on California's recycling rate. Louisiana's recycling rate remains less than half of California's. Increased recycling would add thousands of jobs to the state, increase the economic base, and provide the state with new additional revenues that it desperately needs while improving the health and welfare of all Louisiana's citizens.

CONCLUSION

Louisiana's Medicaid budget is being strained as a result of increased Medicaid rolls, overutilization, and changes in the federal match rate. The Department of Health and Hospitals has initiated several proactive steps to control costs, while ensuring that individuals with disabilities and those who are elderly get the care they need. Cost-saving measures and streamlining have resulted in over $35 million in cost savings last fiscal year alone. New sources of revenue are needed in order to ensure an adequate community-based private provider infrastructure for the provision of services to about 16,000 currently receiving waiver services, about nearly 17,000 in state funded community-based services and the over 27,000 individuals who are waiting for services. The HCR 234 task force identified various means of generating revenue, including: Individual Voluntary Contributions, Local Contributions, Louisiana Lottery, Public Private Partnerships, State Self-Generated Funds, Prepaid Developmental Disability Savings Programs, and Other (Cash Redemption/Refund Program for Beverage Container Recycling). The HCR 234 task force recommends continued implementation of resource allocation and systems rebalancing to better use current resources. The task force also proposes an initial focus on the use of local contributions and public private partnerships as viable funding options as considerable research has already been conducted. These innovative options could further ensure Louisiana can meet the needs of individuals with disabilities and those who are elderly.

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[v] CalRecycle. "Calendar Year 2009 Report of Beverage Container Sales, Returns, Redemption, & Recycling Rates." Department of Resources Recycling and Recovery: Division of Recycling. 2010. 7 September 2010. <v>.

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ENROLLED

Regular Session, 2010

HOUSE CONCURRENT RESOLUTION NO. 234

BY REPRESENTATIVE SIMON AND SENATOR ALARIO

A CONCURRENT RESOLUTION

To urge and request the Department of Health and Hospitals to create a task force which shall study funding options for services to persons with disabilities and the elderly and to report findings and recommendations of the study to the House Committee on Health and Welfare, the Senate Committee on Health and Welfare, the House Committee on Appropriations, and the Senate Committee on Finance on or before January 31, 2011.

WHEREAS, the mission of the Department of Health and Hospitals (DHH) is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the state of Louisiana; and

WHEREAS, Louisianians with disabilities and those who are elderly are in need of services that will enable them to live healthy, independent, and productive lives; and

WHEREAS, despite the best efforts of DHH to address the needs of individuals with disabilities and those who are elderly, there are over nine thousand four hundred individuals awaiting services through the DHH office for citizens with developmental disabilities; and

WHEREAS, in addition, there are over eighteen thousand individuals awaiting services through the DHH office of aging and adult services, many of whom have been waiting for years for community-based services and will die before ever receiving help; and

WHEREAS, nationally, community-based services are considered best practices and are more cost-effective than state-operated institutional services; and

WHEREAS, the state budget crisis has resulted in repeated cuts to community-based services; and

WHEREAS, community-based providers cannot continue to operate when the state reimburses at a rate lower than the basic costs necessary to provide services; and

WHEREAS, this lack of adequate funding noto nly threatens the health and safety of individuals receiving community-based services, it also threatens the state's capacity to serve individuals in the community; and

WHEREAS, the National Conference of State Legislatures issued a report in August 2009 that outlines innovative funding and cost-saving practices which various states are employing to finance services for individuals with disabilities and those who are elderly; and

WHEREAS, other states have addressed funding shortages by identifying new revenue sources and cost-saving measures; and

WHEREAS, it is anticipated that Louisiana will continue to have limited state general funds in future years, and therefore must identify new sources of revenue and cost-saving measures if the state is to adequately meet the ongoing needs of individuals with disabilities and those who are elderly.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby urge and request the Department of Health and Hospitals to create a task force which shall study funding options for services to persons with disabilities and the elderly and to report study findings and recommendations to the House Committee on Health and Welfare, the Senate Committee on Health and Welfare, the House Committee on Appropriations, and the Senate Committee on Finance on or before January 31, 2011.

BE IT FURTHER RESOLVED that the members of the task force shall include representatives from offices and organizations that the Department of Health and Hospitals determines can provide the best information regarding sources of funding for services to persons with disabilities and the elderly, including but not limited to representatives from the Medicaid program, the office of aging and adult services, the office for citizens with developmental disabilities, and other individuals as deemed appropriate by the department.

BE IT FURTHER RESOLVED that the report of the task force may include input and findings from members of the House and Senate health and welfare committees, the House Committee on Appropriations and the Senate Committee on Finance.

BE IT FURTHER RESOLVED that a suitable 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