John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

March 1, 2016

The Honorable Alario, President
Louisiana State Senate
P O Box 94183, Capital Station
Baton Rouge, LA 70804-9183

The Honorable Barras, Speaker
Louisiana State House of Representatives
P.O. Box 94026, Capital Station
Baton Rouge, LA 70804-9062

The Honorable Mills, Chairman
Senate Health and Welfare Committee
Louisiana State Senate
P O Box 94183, Capital Station
Baton Rouge, LA 70804-9183

The Honorable Hoffman, Chairman
House Health and Welfare Committee
Louisiana State House of Representatives
P.O. Box 94183, Capital Station
Baton Rouge, LA 70804-9183

Dear President Alario, Speaker Barras, and Honorable Chairs:

House Resolution 197 and Senate Resolution 191, both of 2015 Regular Session, urges the Louisiana Department of Health and Hospitals (DHH) to develop a study committee on family caregiving and long-term care services. As directed by the Resolutions, DHH convened a study committee consisting of the following members:

1. One member representing AARP Louisiana (Denise Bottcher)
2. One member representing the Southern University Department of Social Work (Donna Gaignard)
3. One member representing the Louisiana Councils on Aging (Albert Robichaux)
4. One member representing the Governor's Office of Elderly Affairs (Tracy Brossard)
5. One member representing the Advocacy Center (Jeanne Abadie)
6. One member appointed by the president of the Senate (Senator Troy Brown)
7. One member appointed by the speaker of the House of Representatives (Representative Hoffman)
8. Two members appointed by the secretary of DHH, one employed by Office for Citizens Developmental Disabilities (Deputy Assistant Secretary Charles Ayles) and one employed by Office of Aging and Adult Services (Assistant Secretary Tara LeBlanc)

The first face-to-face meeting of the study committee was conducted on August 13, 2015, followed by conference calls on September 30 and November 10, 2015. At the first meeting, committee members agreed upon the six deliverables included in both resolutions. The subsequent meetings continued discussions of the research, recommendations, and findings

related to family caregiving, home and community based services (HCBS) and the relationships and impacting factors between the HCBS providers and DHH.

DHH has the responsibility of overseeing all Medicaid funded Long-term Supports and Services provided in the State of Louisiana. DHH's 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 guidance and assistance to family caregivers. DHH recognizes the important roles family caregivers provide to the vulnerable population including disabled, elderly, and those suffering from behavioral issues. DHH also ensures those populations have the access to non-institutional, home and community based alternatives.

Like other states, Louisiana continues efforts to "rebalance" the state's long-term care systems to provide greater access to non-institutional, home and community-based alternatives with a goal of assisting people in remaining a part of their communities. Long-term supports and services, or long-term care, consists of: (1) institutionally-based services (e.g., nursing homes and intermediate care facilities); (2) services in alternative residential and community settings (e.g., assisted living); and (3) personal supports and services provided to people in their homes.

A long-term care supports and services system must be assessable, sustainable, and effectively provide the necessary services to ensure the health and safety of a vulnerable population. As a function of sustainability, the appropriate funding must be available to provide the access and services. However, Louisiana has been faced with a declining financial environment over the last several years. Meanwhile, DHH recognizes that assuring quality of services and access to services has never been more important due to the growth in this population.

It's important to note that unpaid family caregivers provide the bulk of care for older Louisianans, in part, because the cost of long-term care remains unaffordable for most middle-income families. In Louisiana, more than 627,000 residents help their aging parents, spouses, and other loved ones stay at home by providing assistance with bathing, dressing, transportation, finances, complex medical tasks like wound care and injections, and more. The value of this unpaid care totals about $5.7 billion. Having robust, high-quality, accessible home and community-based services is critical to family caregivers.[1]

According to a recent survey of Louisiana voters age 45 and older, Louisianans overwhelmingly want to live independently at home for as long as possible with the help of family caregivers. In fact, the vast majority of Louisiana voters surveyed say it is important to have services that allow people to stay in their own home as they age (90 percent).[2]

Below are the major factors identified by the committee that was reviewed, researched and studied:

OPTIONS FOR DECREASING WAITING LISTS FOR WAIVER SERVICES AND HCBS

Currently, approximately 40,000 individuals are on the waiting list to receive Medicaid waiver services. One of the keys to increasing access to home and community-based services, including waiver services, is assuring that those services are cost-effective compared to nursing facility care and intermediate care facilities for individuals with intellectual/developmental disabilities. The Office for Citizens with Development Disabilities (OCDD) implemented a Resource Allocation

[1] www.longtermscorecard.org

[2] http://www.aarp.org/research/topics/care/info-2015/2014-Caregiving-Survey-Louisiana-Registered-Voters.html

system to address this need, and it has been highly effective in re-balancing the system. Currently, approximately 13,000 individuals are on the waiting list to receive OCDD's comprehensive waiver services. In addition, there are slightly less than 15,000 persons on registries waiting for access to OCDD Medicaid home and community-based services. Analysis of persons waiting on these registries has revealed that 88% of these individuals are or have been Medicaid eligible. Further analysis revealed that 45% of these individuals are receiving either long-term care through another waiver program, long-term care personal care services, nursing home, ICF-DD, or OCDD state funded services.

Each of OCDD's I/DD waivers is cost-effective against the current combined cost of public and private ICF-DD services. The New Opportunities Waiver at $52,000 per recipient is almost 40% less than the combined ICF-DD cost for state fiscal year 2014-2015. The average cost of community-based programs operated by OAAS for the aging population, both waiver and state plan personal care services, is now less than 50% of nursing facility care.

The study committee offered two recommendations on how to decrease the number of individuals currently on the waiting list to receive waiver services. First, implement managed long-term supports and services to include all long-term care services and second, increase the funding provided for home and community- based services.

- **Managed Long-Term Care Supports and Services (MLTSS)**

  18 states currently operate managed long-term services and supports to control costs and rebalance the traditional long term supports and services delivery system to better meet the desires of most people who prefer to live in their own homes and communities rather than nursing facilities. Managed care is the predominant Medicaid payment and delivery system in most states and many states are trending toward managed MLTSS, including Louisiana. Just as payment capitation provides an incentive to make greater use of nursing facilities for hospital step-down and sub-acute care, so too does it provide a structural incentive to reduce nursing facility utilization when less expensive community-based care can achieve equal or better outcomes. And, as stated previously, provide the in-home services that most people prefer.

  In the report entitled, "Update on Louisiana's Concept for Medicaid Managed Care for Older Adults and Persons with Adult Onset Disabilities," authored and published by Louisiana's Department of Health and Hospitals, Office of Aging and Adult Services (OAAS), it is stated that "it will be possible to reduce waiver waiting lists, continue rebalancing, expand access to behavioral health services, improve health care outcomes, and expand use of consumer-directed services..." through the implementation of MLTSS. DHH has also publicly stated that MCOs would be expected to meet or exceed current benchmarks for nursing facility transitions to the community under Money Follows the Person.

  Impact studies done by DHH indicate that during the second year when managed long-term services and supports is in effect, there is an approximate savings of 30 million dollars. That savings is only realized if all services encompassing long-term care are included.

- **Adequate funding appropriated to DHH by the Legislature to support providing waiver offers to recipients waiting on home and community-based waiver services**

The simplest and most direct way of addressing the large and growing number of individuals on the waiting lists for Louisiana's elderly/disabled waivers is to authorize and fund additional waiver slots. The Community Choices (CCW) and Adult Day Health Care (ADHC) waivers are very cost-effective, 55% and 51%, respectively, in terms of average per person cost compared to nursing home care, and there is evidence that the availability of community-based alternatives has slowed the rate of growth in nursing facility utilization. Authorizing and funding additional New Opportunities Waiver (NOW) slots would be effective in reducing the number of individuals on the waiting list for Louisiana's intellectual/developmental disabilities waiver.

The NOW waiver is the State's largest and most comprehensive I/DD home and community based services program. The program's annual expenditures have nearly reached $440 million with an average annual individual recipient cost of $52,000. With a waiting list of nearly 13,500 individuals, it would cost the state nearly $650 million annually to provide fully funded slots for individuals on the NOW registry. Whereas it may be ideal that the state would dedicate an additional two-thirds of a billion dollars to fully eradicate the waiting list for services, the current budget realities of the state makes that nearly impossible imagine.

HCBS MEDICAID PAYMENT RATE

Over the past several years, Louisiana has been faced with declining revenue. As a measure to meet the revenue available, DHH has reduced Medicaid home and community-based service provider rates. With the changing environment surrounding employer requirements for healthcare, overtime, and other administrative requirements, DHH recognizes the need to review Medicaid provider rates.

A first step in any strategy to address provider rates is to look at the actual cost of service delivery. Current rates were developed based on knowledge of rates paid in other states and were reduced to deal with budget shortfalls, but no real work had been done to develop a cost-based methodology and rationale for rate setting. A resolution of Act 299 of the Regular 2012 Session was the development of submission of cost reports by HCBS providers. Thus, beginning in 2013, HCBS providers began submitting cost reports. DHH is utilizing the cost reports to capture cost data, direct-care and non-direct care, components for providing services.

Recently, DHH has worked with an independent actuary/consultant to assist with delivering a rate methodology and appropriate payment rate using cost report data submitted by HCBS providers. (See attached rate methodology and calculated rate on Exhibit 1.) Please note that DHH is not currently appropriated the level of funding required to support providing any rate increase to HCBS providers. Therefore, there is concern that with increased expenses to home and community-based providers and no budgetary increase, home and community-based service provision will be an unsustainable business.

The following table compares the Medicaid rates for HBSC services from SFY2008 to current state fiscal year.

Table 1			
Medicaid Service	**Current Rate (SFY16), per 15 minute increment**	**Rate SFY08, per 15 minute increment**	
Personal Care Services	$ 2.85	$ 3.50	
EPSDT	$ 2.53		
Companion Services (EDA)	$ 2.79	$ 2.50	1
Community Choices Services	$ 2.79	$ 2.89	1
Children's Choice Services	$ 3.50	$ 3.75	
Residential Optional Waiver Services (ROW)	$ 3.61		2
Supports Waiver Services	$ 3.71	$ 4.00	
NOW Services	$ 3.61	$ 4.00	3
NOW Services	$ 2.17	$ 2.25	4
1 - In 2010, EDA companion care services was converted to Community Choices Services			
2- OW was implemented in 2010			
3 -Day Shift			
4 -Night shift			

RATE IMPACT ON HCBS MEDICAID PROVIDERS

Recent years have seen a reduction in the number of HCBS provider agencies licensed to provide services in Louisiana. Given state costs associated with assuring provider quality and compliance, some of this market constriction is arguably beneficial, especially since there has been little to no resulting loss of access to services. Clients in all regions of the state continue to have access to multiple provider agencies and long "freedom of choice" lists. There is no shortage of HCBS provider agencies in any region of the state. However, it is becoming harder for people living in rural areas to find providers that have staff willing to drive to remote areas, especially if that person is only receiving two-three hours of service per week.

That said, since 2012 there has been reduction in providers licensed to provide community based services. However, DHH does not track the reason providers have exited the system. In 2012, 1,092 of providers held a HCBS or ADHC license through DHH-Health Standards. In 2015, that number dropped to 605 licensed providers. While it is tempting to point to rate reductions, no direct relationship can be drawn between rate setting or rate reductions and the availability of HCBS providers since multiple factors impact shifts in the number of provider agencies operating at any point in time. Louisiana does not keep data regarding why providers exit the system. Rate reductions could certainly play a role in the decrease in providers, but the following are other factors that impact the provision of home and community-based services. The following factors play a role:

1. Historically, Louisiana has had a large number of providers, especially smaller providers serving fewer than 50 individuals. Even currently, 14% of provider agencies serve fewer than 10 individuals. Since 2012, data indicates some consolidation of caseload with a higher percentage of recipients selecting providers who serve more than 50 service recipients and a reduction in the percentage of providers serving fewer than 50. It is possible that these client-driven market shifts towards greater consolidation with larger providers have resulted in a loss of smaller and mid-sized providers.

2. Greater use of consumer-directed services, in which recipients hire their workers directly rather than going through an agency, may also have impact on total number of provider agencies. There are currently over 475 persons using self-directed services.

3. Consolidated licensing allows new agencies coming into the market to operate with fewer licenses than was previously the case. At the same time, more challenging licensing requirements beginning implementation in 2013 to improve provider quality and stability (such as requiring reserve or line of credit sufficient to meet payroll) have reduced the number of new providers coming into the field.

4. The impact of federal regulations such as the Affordable Care Act (ACA) and US Department of Labor Overtime Rule place financial and administrative burden on providers. The impact from each of these has greatly affected the direct employment costs of providing home and community-based services. The mandate in ACA that employers of more than 50 employees provide health insurance for their employees is an expense that is new. Although many of these workers could fall below 138% or poverty and receive Medicaid, Louisiana chose not to expand Medicaid eligibility as allowed by ACA, so the burden of the cost of health insurance is fully on the home and community-based provider. In October of 2015, a federal appeals court decided that the Department of Labor could implement a rule that would no longer exempt in-home caregivers from overtime pay. Many of the employees of home and community-based provider agencies work many more than 40 hours per week, sometimes because that is the only way to make ends meet and sometimes because the recipient they are serving has a disability that is not conducive to having several workers provide his/her care. Therefore, providers are forced to pay time -and- a-half for every hour worked over 40 hours per week. Providers are paid a range of $8.68 - $14.84 per hour. If an employee is paid minimum wage of $7.25 per hour, paying time-and- a-half would cost $10.88.

A far more significant barrier to services provision than number of licensed agencies is the difficulty in attracting, recruiting, and retaining a good quality workforce (a situation that is only exasperated by having too large a field of licensed agencies). Providers also find it difficult to pay a decent wage and provide benefits when the Medicaid reimbursement rate ranges from $8.68 - $14.84 per hour. Although, services are provided to Medicaid recipients as determined by the recipient plan of care. HCBS providers are facing challenges in recruitment and high turnover rates.[3]

Lastly, the Office of Aging and Adult Services (OAAS) currently allows a family member to be a paid service worker. Of the OAAS population service, 18.2% of HCBS service workers are

[3] Source: CMS Coverage of Direct Service Workforce Continuing Training within Medicaid Policy and Rate Setting: A Toolkit

family members. OAAS also allows a person that lives with the recipient to provide services to that recipient regardless of the relationship. For most services, OAAS does not allow a spouse or a legal guardian to perform in the role of the paid worker.

ADMINISTERING HCBS MEDICAID SERVICES

DHH policy decisions affecting home and community-based services and providers are made with recipient safety and welfare as the focal point as well as ensuring compliance with federal regulations. DHH continuously reviews policies to ensure they are the most effective and are in compliance. Act 299 of 2012 Regular Session required DHH to conduct an in-depth review of policies related to administering home and community-based services. Please refer to the report submitted by DHH on January 16, 2012 for details of the implemented policy changes to improve the administration of home and community-based services. Below are major policy changes which resulted in reduction of administrative requirements of Medicaid HCBS providers.

- Consolidated licensure
- Cost report filing for HCBS providers
- In-Home Technology
- In addition to Act 299 of the 2012 Regular Session, the Department has implemented the following to assist HCBS providers:
  - Medication administration
  - Standardized training requirements
  - Decreased expense for HCBS provider related to obtaining driving record for employee

The Office for Citizens with Developmental Disabilities (OCDD) is currently working to combine the four current waivers into one consolidated waiver for individuals with intellectual/developmental disabilities. Currently, developmental disability waiver services are distributed across four 1915(c) waivers with different services in each waiver. This design was reported to be confusing for recipients and unwieldy for staff. These waivers are being consolidated into a single 1915(c) waiver (consolidated NOW), which combines many services and adds new service coverage.

On behalf of the study committee, we would like to thank the legislature for continuing to place this vulnerable disabled and elderly population, a top priority for ensuring their safety and welfare.

Sincerely,

Tara A. LeBlanc,
Assistant Secretary
DHH- Office of Aging and Adult Services

Attachments:
HCBS Rate Methodology

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Rate Calculation

Personal Care (PCS) and Personal Care Attendant (PCA) Services Rate Model

Validation of Current Rates			
1 Client Billing Codes			
Billing code	Calculated Rate	Current Rate	Variance
T1019 UB (PCS)	$ 3.52	$ 2.85	$ 0.67
T1019 EP (EPSDT)	$ 3.52	$ 2.53	$ 0.99
S5125 (Comm)	$ 3.52	$ 2.79	$ 0.73
S5125 (Children's)	$ 3.52	$ 3.50	$ 0.02
S5125 (ROW)	$ 3.52	$ 3.61	$ (0.09)
S5125 (Supports)	$ 3.52	$ 3.71	$ (0.19)
S5125 U1 (NOW)	$ 3.52	$ 3.61	$ (0.09)
S5125 UJ (NOW)	$ 3.52	$ 2.17	$ 1.35

A. Identify required direct service staff and develop hourly wage rates using LA occupational wage data, and information collected from submitted Medicaid cost reports.

Staffing Category	SOC Code	Louisiana Workforce Commission Occupational Wage Data SOC Description	Selected LA Occ Wage Data Percentile	LA Occ Wage Data Hourly Wage	% of Occ Wage Data Rate	Average Cost Report Wage Rate [b]	% of CR Wage	Blended Rate
Direct Service Worker	39-9021	Personal Care Aides	50th Percentile	$8.57	0%	$8.89	100%	$8.89

B. Determine number of clients to one staff.

Number of Clients for One Staff	1

C. Add an employee benefit factor.

Base Benefit Percentage on Cost Report Data or Other Source	Cost Report

Benefits as % of Wage	Cost Report	Other Source
	12.50%	

	1 Client Cost Per Hour	
Benefits as % of Blended Wage Rate	12.50%	
Additional Health Insurance Add-on %	5.00%	[c]
Total Benefits as % of Blended Wage Rate	17.50%	
Add-on to Hourly Staff Costs For Benefits (Excludes Overtime	$1.56	

Overtime Hours as % of Weekly Employee Hours	13.25%	[d]
Overtime Reimbursement Multiplier	150.00%	[d]
Total Overtime Adjusted Wage Rate	$9.48	

Total Hourly Staff Costs	$11.04

D. Determine number of face-to-face hours and adjust hourly staff cost to account for "non-billable" hours.

	1 Client Cost Per Hour
Total Paid Hours per Day	8.00
Documentation and Meeting Time [e]	0.03
Training [e]	0.05
Paid Time Off/Substitute Staff [e]	0.022
Other [e] (Wait Time, Supervising, etc.)	0.023
Total "Billable/Productive" Hours	7.875
Productive Hours Adjustment	1.0159
Adjusted Hourly Staff Cost	$11.22

Ratio of Staff to Client	1.00
Hourly Staff Cost per Client	$11.22

E. Identify other hourly expenditures as a percent of hourly staff costs.

Base Rates on Cost Report Data or Other Source	Cost Report

Other Hourly Expenditures	% of Hourly Staff Costs (Cost Report)	% of Hourly Staff Costs (Other Source)
Capital	1.96%	
Transportation	0.76%	
Supplies / Other Direct Expenses	0.15%	
Other Overhead	29.27%	

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Rate Calculation

Personal Care (PCS) and Personal Care Attendant (PCA) Services Rate Model

F. Calculate other hourly expenditures.

Other Hourly Expenditures	1 Client Cost Per Hour	
Capital	0.17	
Transportation	0.07	
Supplies / Other Direct Expenses	0.01	[b]
Other Overhead	2.60	
Hourly Other Expenditures	$2.85	
Ratio of Staff to Client	1.00	
Overhead Cost per Client	$2.85	

G. Calculate the total rate per hour (without profit factor)	1 Client Cost Per Hour
Staff	$11.22
Overhead	$2.85
Total Rate Per Hour (Per Client)	$14.07
Total Rate Per 15 Minute Increment	$3.52

[a] Estimates of staff non-productive time have been provided by OAAS. Those results were based on a survey of providers.

[b] Contract labor services were removed from the other direct services category manually during the review process, where noted. The removed contract labor services were then utilized in the establishment of the per hour wage rate noted in the above analysis.

[c] The estimated percentage was determined from a review of HCBS provider 2013 year end cost reports and other provider type cost reports. A small portion of health insurance expense may be included in the initial benefit percentage, as there is not a direct way to carve this expenditure out of HCBS provider cost reports without a 100% review. As such the health insurance benefit percentage above is an additional percentage.

[d] Overtime hours were provided through an analysis prepared by OAAS using the SRI system. The overtime rate is calculated at the minimum overtime rate established by the US Department of Labor (150% of standard wage rate).