Research Brief

Public Affairs Research Council of Louisiana April 2010

Working Toward a Client-Centered and Cost-Effective Approach to Medicaid Long-Term Care for the Elderly

Executive Summary

The Louisiana system of publicly-funded long-term care for the elderly has been improved in recent years to achieve a better mix of institutional and non-institutional options for care. However, the state health care budget for the next fiscal year proposes a move in the opposite direction and would reduce funding for home and community-based services while increasing funding for nursing home care.

The Medicaid long-term care system should be viewed as a continuum with nursing homes and in-home care occupying equally important but different roles according to the needs of the population they serve. The elderly and adults with disabilities generally prefer to live independently at home instead of being institutionalized in nursing homes. The preferred option costs substantially less than the institutional option. While there is a high vacancy rate and no waiting list for nursing home beds, there are currently around 18,000 people awaiting approval for home and community-based services. Louisiana now spends more than $1 billion on long-term care for the elderly with almost 70 percent of dollars going to institutions that are nearly 30 percent empty.

Other states have found ways to successfully balance institutional care with home and community-based care so that a broad continuum of services is available to meet a variety of needs, depending on individual capabilities and preferences. Louisiana has been moving in the right direction in recent years, but the proposed budget raises concern that progress could be reversed. Additionally, the state's financing mechanisms for long-term care for the elderly are biased toward support of nursing home care and should be adjusted to achieve a better mix of institutional vs. non-institutional care.

The Louisiana Medicaid program budget as of January 2010 was $1.02 billion for private long-term care services for the elderly population. This figure included $724 million (71 percent) for nursing homes and $297 million (29 percent) for all types of in-home and community-based care. The Executive Budget proposal for next fiscal year calls for a net increase of $16 million, or 2 percent, for nursing homes and a net decrease of $61 million, or 20 percent, for home and community-based care. The 20 percent adjustment is much higher than the overall net reduction of 5.7 percent imposed on the entire Medicaid program.

Significant changes for home and community-based care include provider rate cuts that total $15 million, increases of $16 million to cover new enrollees and a $62 million reduction in personal care services that will be achieved by decreasing the maximum allowable hours of care to an unspecified amount below the current maximum of 42 hours per week. The state Department of Health and Hospitals (DHH) is studying similar programs in other states to determine a new service-hour cap and is also considering other options, including a possible change to stricter eligibility standards.

The proposed cap on services is a cost containment measure that might be a reasonable approach to expanding the number of people who can be served while limiting costs. However, it would be a mistake to redirect the

savings to anything other than serving additional participants who are currently on the waiting list for specific waiver services, i.e., special federally approved programs designed to enable independent living for persons who would be at risk of being placed in an institution. The entire amount of the savings of $62 million should be redirected to the waiting list of persons who have applied for Elderly and Disabled Adult (EDA) Waiver services (16,940 waiting) or the Adult Day Health Care (ADHC) Waiver (1,259 waiting).

This budget cut, combined with a proposed increase in funding for nursing home care, reflects a priority shift in the wrong direction by reducing the proportion of spending on in-home care from current levels of 29 percent to 24 percent for next year with a significant reduction in availability of services. As further massive budget cuts loom for Louisiana and the state searches for more cost-effective ways to spend its scarce dollars, it would be a mistake to shift funding from less-expensive in-home care to more expensive nursing home care.

The Legislature could intervene to prevent a reversal of the state's recent gains toward the de-institutionalization of long-term care for the elderly. Since release of the Executive Budget, additional federal dollars have been made available for state Medicaid programs and more is likely to be approved by Congress in the weeks ahead. These funds can be used to plug gaps in the budget, especially those that are most troublesome such as the disproportionate cuts to in-home care for the elderly. The budget and policy changes recommended in this research brief would help the state continue its progress toward a better integrated and coordinated system of long-term care for its elderly population.

Recommendation 1: Reduce the 18,000-person waiting list for in-home and community-based care by redirecting $62 million generated by cost-control measures into the Elderly and Disabled Adult (EDA) and the Adult Day Health Care (ADHC) waiver programs.

Recommendation 2: Implement a tracking and reporting system that will ensure the state continues its shift toward a better balanced continuum of long-term care for the elderly that provides more home and community-based care options.

Recommendation 3: Change the laws governing the use of the Elderly Trust Fund to allow interest earnings to be spent on services provided in nursing home and home-based settings.

Introduction

Since the mid-1960s, the Louisiana Medicaid program has provided financing for a system of long-term care for the low-income elderly population. For more than 40 years that system offered institutional care in the form of nursing homes but offered very little in terms of in-home options for those persons able to live independently with proper supports and services. Louisiana has lagged far behind most states in this regard, despite protests from client advocacy groups.

After the 2002 settlement of a federal lawsuit (Barthelemy v. Hood) that sought to force the state to devote more resources and funding to establish in-home care for the elderly and adults with disabilities, spending began to shift rapidly. (NOTE: The author of this report served as secretary of the state Department of Health and Hospitals from 1998 to 2004 and was named as defendant in the Barthelemy case by virtue of that role.) In 2002, total spending on in-home care was only 1.4 percent of total long-term care spending. By 2005 the proportion had increased to 10.7 percent and by 2010 had rapidly climbed to 28.5 percent. During this same time period, nursing home occupancy rates dropped from 78 percent to 72 percent. Declining demand for nursing home beds in Louisiana combined with long waiting lists for home and community-based services indicate a pent-up demand for in-home care that will require a disciplined and consistent policymaking focus to satisfy.

The executive budget proposed in February raises concern that recent progress in moving toward a system that provides more of the lower-cost in-home care could be reversed. Funding for nursing home care is proposed to increase while funding for in-home care is proposed to be cut. There is a high vacancy rate with more than 9,000 empty beds and no waiting list for nursing home care while the waiting list for in-home care services is about 18,000 people, according to the state Department of Health and Hospitals (DHH).

The proposed budget cuts for fiscal year 2011 are tied to a new limitation on the number of service hours each approved participant would be eligible to receive. This limitation could force some participants currently living at home to seek care in nursing homes – thus increasing the cost of their care.

The Legislature can intervene to prevent a reversal of the state's recent gains toward the de-institutionalization of long-term care for the elderly. Additionally, the state's financing mechanisms for long-term care for the elderly are biased toward support of nursing home care and should be adjusted to achieve a better mix of institutional vs. non-institutional care.

Status of Louisiana long-term care system

The Medicaid long-term care system in Louisiana includes both institutional and non-institutional services. Institutional care is almost exclusively nursing home care, although there are long-standing plans to implement pilot projects for assisted living services. Non-institutional care includes various home and community-based services (HCBS) that focus on maintaining or improving the ability of elderly and chronically disabled persons to function as independently as possible for as long as possible.

In-home care includes a wide range of supports and services geared toward individuals who live in their own homes, the homes of relatives or other types of residential care facilities. Examples of these services are bathing, dressing, eating and assistance with household chores such as meal preparation and house cleaning. Equipment and assistive devices, ranging from canes and walkers to medication reminders, emergency alert systems and home modifications such as ramps and handrails, are not currently available for the elderly waiver program but are provided for programs that serve persons with developmental disabilities.

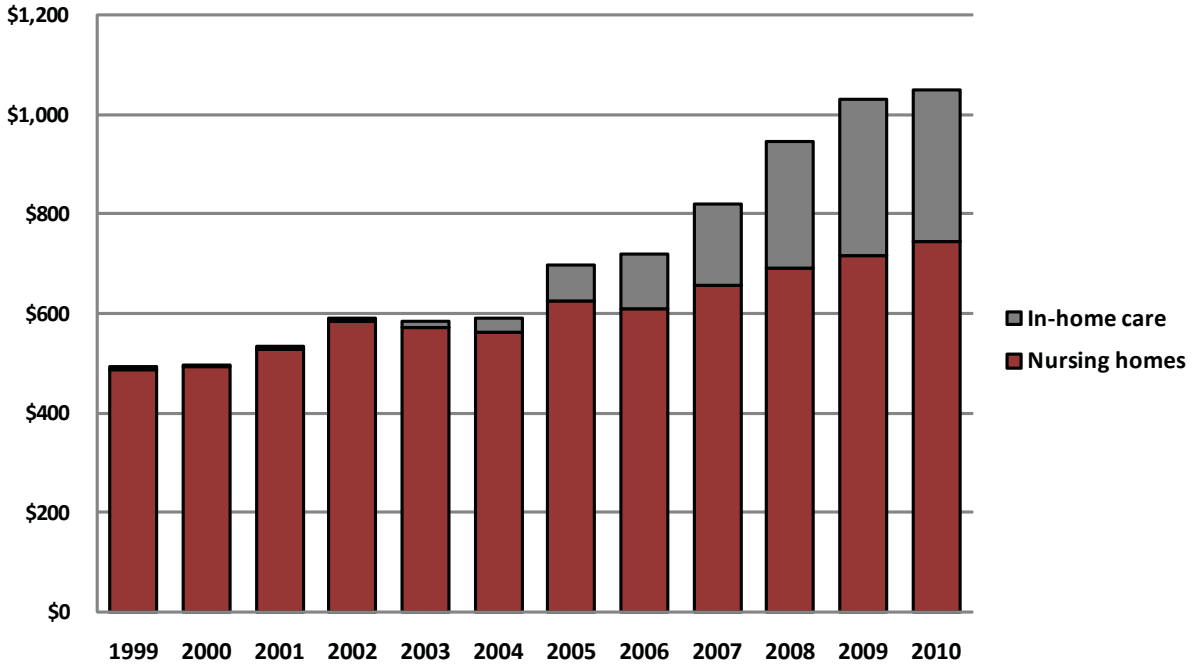
Adult day health care provides meals, basic health care and recreational activities at community locations. One program called PACE (Program of All-inclusive Care for the Elderly) complements day-care services with access to primary medical care and also arranges for hospitalization and nursing home care when required. The Medicaid program (or other payer) pays a single fee to the PACE provider (usually a nonprofit entity) for most services required by the participant. PACE was initiated in New Orleans in 2007 and in Baton Rouge in 2008. Other states successfully operate PACE programs, so the program may have potential as a vehicle for enhancing services in the continuum of care statewide in Louisiana.

Home health care also is available to elderly and disabled Medicaid recipients who require specialized nursing, therapeutic services or other medical care, but it is generally viewed as part of the acute medical care system, rather than a component of long-term care.

HCBS are regulated through special federally approved programs that require overall costs to be lower than the cost of institutional care. These programs are called "waivers" because the federal Department of Health and Human Services is allowed to waive certain provisions of federal law that otherwise would forbid funding of these programs. Medicaid did not pay for in-home care until the early 1980s when special rules were introduced as an option for states interested in providing services for those who choose to live independently outside of an institution.

The pace of adoption of these waiver services by states was deliberate at best and downright slow in some states, such as Louisiana. However, waiver funding has accelerated since 2000, particularly with respect to in-home care for persons with developmental disabilities. Louisiana currently spends about 30 percent of all long-term care funds (care

Figure 1. Louisiana spending for long-term care service ($ millions)



Source: Louisiana Department of Health and Hospitals

for the elderly, for persons with mental illness and for persons with developmental disabilities) on in-home care compared to the national average of 40 percent.

Although progress has been slower with respect to care specifically for the elderly, adoption of alternatives to institutionalization for the elderly has been increasing over the past five years. The Barthelemy v. Hood lawsuit forced the state to increase spending on non-institutional care. As a result, spending on in-home care and other community-based services has grown from about $8 million in 2002, the year of the settlement, to $75 million by 2005, and to $297 million in the current fiscal year (see Figure 1). The number of persons served has increased from about 3,000 per year to 15,000 during the same period.

The growth of a more robust system of in-home care has been a welcome development for a large number of elderly persons but it also has caused a significant increase in waiting lists for those same services. More than 18,000 persons are currently on waiting lists for in-home care with average waiting times of two years or more.

Long-term care budgets for FY 2010-11

Medicaid was established by Congress in 1965 as a federal-state partnership to provide health care primarily for low-income persons who could not afford health insurance. A major recurring complaint from the beginning was that during economic downturns when more people were unemployed, state revenues usually plummeted and budgets were cut. A primary target of budget cuts was always the state Medicaid program with the result that public health care services were likely to be less available in times when they were needed most.

Four and a half decades later little has changed. A report released in February 2010 by the Kaiser Family Foundation on Medicaid and the Uninsured found that 44 states are experiencing higher than expected Medicaid enrollment and at least 29 states are considering additional midyear cuts in provider rates and program benefits. The American Recovery and Reinvestment Act (ARRA) provided additional federal matching funds for states, and those funds may be available until June 30, 2011, if Congress extends the current deadline of Dec. 31, 2010, alleviating some of the pressure on strained state budgets.

The Louisiana Medicaid program is feeling the impact of job losses and enrollment increases, although in each case the state's rate is still below the national average. But Louisiana is dealing with an additional burden in the form of a significant decrease in the federal matching rate or FMAP (Federal Medical Assistance Percentage), which may cause the federal share of program spending to drop from about 81.5 percent with ARRA funds to 67.6 percent when ARRA expires. The Medicaid budget for FY 2010-11 incorporates plans to deal with the resulting shortfall on the assumption that additional federal funds will not be available to address the FMAP issue.

The Governor's Executive Budget announced in February calls for Medicaid funding of $6.15 billion, a reduction of $372 million, or 5.7 percent, from the current-year budget level of $6.52 billion. The impact of reductions on individual programs varies widely. In-home care for the elderly is reduced by $61 million net, or 20 percent, proportionately larger than reductions for other programs.

Remedies for this situation may be available for the next two budget cycles, with one solution under consideration by Congress and the other already a reality with passage of the health reform act. Congressional action to extend the enhanced FMAP rate to June 30, 2011, has passed the House of Representatives and is expected to pass the Senate in the next few weeks. If it passes, Louisiana's FMAP of 81.5 percent would be maintained through the upcoming fiscal year, adding an estimated $428 million in federal funds to the Medicaid budget. This could enable the restoration of a number of budget cuts, including those that target home and community-based services for the elderly. Waiting list reductions could be made a top priority.

Further budget relief will be provided through the now-famous Louisiana amendment to the recently passed health reform act. That amendment provides an estimated $325 million to offset the reduction in federal funds following Hurricane Katrina recovery activities. According to DHH, these funds could be used to address shortfalls from changes in the federal Medicaid funding formula either in FY 2010-11 or FY 2011-12, depending on the availability of other funds pending congressional action as described above.

While at least partial relief for Medicaid budget problems is now available, there is no guarantee that these funds will be used to reverse the worst budget cuts and address the most pressing needs.

LT-PCS. The Long-Term Personal Care Services (LT-PCS) program enables clients to live independently at home or in community settings with a basic level of care that is often used as a stepping stone to more extensive care provided only after a waiver slot becomes available.

As proposed, the FY 2010-11 budget for the LT-PCS program will see a net reduction of $61.1 million, or 27 percent, from its current budget of $233 million as follows:

- $61.7 million reduction related to a decrease in service hours provided to clients;
- $12.7 million reduction for provider rate cuts; and
- $13.3 million increase to add 1,560 additional clients.

For the upcoming fiscal year, the hours of care each client can receive will be reduced below the current 42-hour per-week maximum. A cap on service hours was set originally in 2003 at 56 per week and then reduced to 42 hours in March 2009. The program will receive another significant cut, perhaps to 25-30 hours (a range used by some states) next year. The impact of the reduction in terms of service levels or numbers of persons served is unknown at this time. Although the service-hour cap will help to control rapidly rising per-person costs in this program, it does so at the risk of leading some to seek care in more expensive institutional settings. If these supports and services are eroded, clients may be unable to sustain a wait of up to two years before they can get the services they need.

Waiver Services. The Elderly and Disabled Adult (EDA) and the Adult Day Health Care (ADHC) waiver programs provide a higher level of care than the LT-

PCS program. At the end of 2009, a total of 18,199 people were waiting to enroll in waiver programs.

The EDA waiver will have a net reduction of $1.5 million or 2.5 percent from its current budget level of $63 million. The $1.5 million cut will impose the 3.1 percent provider rate cut. The program serves almost 5,000 clients but had a waiting list of 16,940 as of Dec. 31, 2009. Funds were made available in the current year for 228 additional waiver slots but those were not filled. Those funds have been carried forward in next year's budget.

ADHC will receive a net increase of $660,000, or 9 percent, from its current budget of $7.4 million, including a cut of $434,000 and an increase of $1.1 million to add 48 slots, bringing total clients served to approximately 1,100. The waiting list totaled 1,259 as of Dec. 31, 2009.

PACE. Program for All-inclusive Care for the Elderly (PACE) is a relatively new program that started in New Orleans in 2007 and provides a wide range of community-based services that help the elderly clientele maintain independence. Program funding will be increased by a net $1.4 million, or 37 percent, from its current budget of $3.5 million. There will be a reduction of about $90,000 for a 3.1 percent rate cut and an increase of $1.3 million for expansion to a third site in Monroe. The program currently serves 130 clients in New Orleans and Baton Rouge and has no waiting list.

Institutional Care. The nursing home budget includes $96 million in various rate cuts that are more than offset by a $112 million increase in funding through a rate "rebasing" procedure. The overall net change is a $16 million, or 2 percent, increase in funding that will total $740 million next year.

This increase is made possible in part because of the existence of the Elderly Trust Fund (ETF), which was established by the Legislature in 2000 and now has invested assets totaling more than $760 million. Each year, the fund provides the state match to increase Medicaid rates and provide other payments to nursing homes. Total funding for in-home care, on the other hand, is determined by the availability of state general fund dollars to match federal Medicaid funding. The ETF provides state match amounts for the nursing home operating budget only in the initial year of a rate increase, but the state is obligated to replace those funds with an appropriation of state general fund dollars in succeeding years.

If the budget is adopted as proposed, the share of long-term care funding that would support institutional care would grow from 71 percent in 2010 to 76 percent in 2011 – the opposite direction of the trend depicted in Figure 1 with the nursing home portion of the budget shrinking. The 2010 legislative session will determine whether the state will continue its historic practice of favoring expensive institutional care for the elderly or continue recent progress toward a more efficient system that accommodates the preferences of Louisiana citizens who prefer to live independently and can do so with less costly services.

Table 1. Nursing home indicators

Nursing Home Indicators	United States	Louisiana	Rank
Total nursing home residents (2006)	1.4 million	27,800	19
Residents/1,000 population age 85+ (2006)	271	411	1
Total certified nursing home beds (2009)	1.7 million	35,425	17
Beds/1,000 population age 85+ (2009)	315	516	1
Occupancy rate (2006)	85%	75%	40
Average nurse hours per resident day (2008)	3.8	3.4	47
Per capita spending for nursing home care (2004)	$392	$360	30

Source: "State Health Rankings," CQ Press 2009; Kaiser State Health Facts 2010.
All data from U.S. Department of Health & Human Services, Center for Medicare & Medicaid Services.

Table 2. Louisiana nursing home beds, residents and occupancy rates

Louisiana					U.S.
Year	Beds	Residents	Empty Beds	Occupancy Rate	Avg. Occupancy Rate
1999	38,393	31,678	6,715	82.5%	86.3%
2000	36,028	28,903	7,125	80.2%	86.0%
2001	36,843	29,114	7,729	79.0%	85.9%
2002	37,479	29,146	8,333	77.8%	85.6%
2003	35,105	26,930	8,175	76.7%	85.5%
2004	37,101	28,005	9,096	74.0%	85.5%
2005	33,737	25,569	8,168	75.0%	85.4%
2006	34,425	25,698	8,727	74.6%	85.2%
2007	34,845	25,787	9,058	74.0%	84.8%
2008	34,803	25,283	9,520	72.7%	84.2%
2009	32,701	23,512	9,189	71.9%	N/A

Source: Centers for Medicare and Medicaid Services, OSCAR database and DHH data. N/A: Not available.

Nursing homes

Although non-institutional options have become more widely available, Louisiana still relies heavily on nursing homes to provide long-term care services to the elderly and persons with disabilities. In the Medicaid private provider program, nursing homes account for $740 million in spending for the current fiscal year, ranking second behind hospital inpatient services at $848 million.

Table 1 compares Louisiana to the national average on seven performance indicators. Louisiana has the 47th worst nursing home occupancy rate in the nation, 75 percent compared to the national average of 85 percent. This equates to more than 9,000 beds unoccupied, with the nursing home population continuing to decline between 1 percent and 2 percent annually. Contrary to expectations, Louisiana has relatively fewer elderly than the national average: The state ranks 36th in the percent of persons 75 and older at 5 percent of the population.

Table 2 shows that the Louisiana occupancy rate has steadily decreased since 1999. State funding is paid according to a formula that compensates for beds whether they are occupied or not. The nursing home cost per day has increased an average of more than 8 percent each year from $65 in 2002 to $108 in 2009. Declining occupancy without corresponding closure of beds and facilities over a number of years can result in a substantial increase in overall spending. This draw on limited funding must be carefully balanced with increasing funding demands for lower-cost in-home care.

Home and community-based alternatives

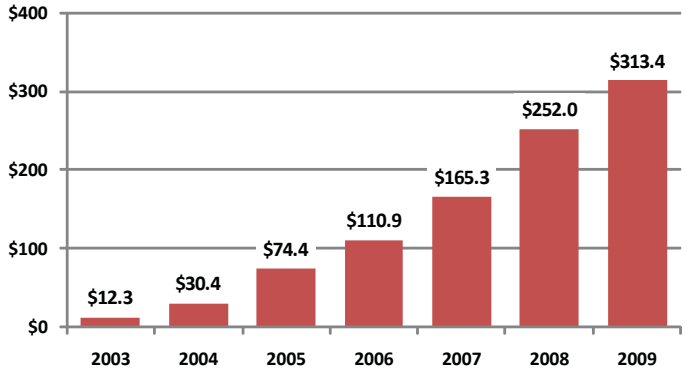
Compared to most other states, Louisiana was late in implementing home and community-based alternatives to institutional care for the elderly. Although in-home care was introduced with the EDA waiver program in 1993, very little funding was provided and participation was well under 1,000 persons. In 2002, the Barthelemy lawsuit settlement spurred expansion of these services, and today the number of participants in various home and community-based programs exceeds 15,000. Given a choice between institutional care and in-home care, participants have exercised their discretion in favor of continuing to live independently for as long as they are able.

Table 3. Medicaid elderly home and community-based services (HCBS) indicators

Medicaid Elderly HCBS Indicators	United States	Louisiana	Rank
HCBS spending per person served (2005)	$9,459	$10,436	15
Nursing home spending per person served (2005)	$26,096	$20,643	41
Persons on waiting list for HCBS (2007)	89,938	9,209	3
Persons currently on waiting list for HCBS (12/31/2009)	N/A	18,199	N/A
Percent of population age 75 and older (2007)	6.1%	5.7%	35
Projected population age 75 and older (2030)	9.2%	9.2%	29

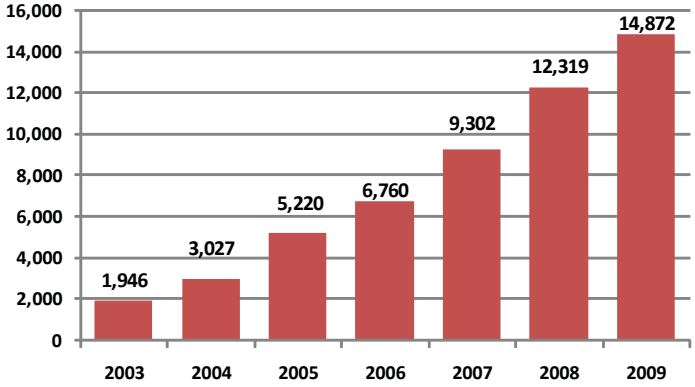
Source: "Across the States: Profiles of Long-Term Care and Independent Living," AARP Public Policy Institute, 2009. Current year data from Louisiana Department of Health and Hospitals (DHH) reports. N/A: Not available.

Figure 2. Louisiana spending for in-home services for elderly and adults with disabilities ($ in millions)



Source: Department of Health and Hospitals, Office of Aging and Adult Services, 2010

Figure 3. Louisiana long-term care clients receiving in-home care (elderly and adults with disabilities)



Source: Department of Health and Hospitals, Office of Aging and Adult Services, 2010

Table 3 provides comparisons of Louisiana to the nation in terms of spending and utilization for home and community-based services for the elderly and disabled adult population. The indicators show that the number of people on the waiting list for in-home care has nearly doubled in the past two years. As of Dec. 31, 2009, there were 18,199 people on waiting lists for services for the elderly, many of them residents of nursing homes. Those who applied for services recently may have to wait as long as two years before they are able to receive those services. Also, the portion of the population that is elderly in Louisiana is projected to rise to the national average by 2030.

Cost has become an issue with non-institutional care over the past five years due to the rapid growth in programs providing in-home services. Pent-up demand for alternatives to nursing home care fueled average annual spending increases of 72 percent and enrollment increases of 41 percent from 2003 through 2009 (see Figures 2 & 3). DHH has reacted with measures to control costs in the face of massive budget problems, as well as to maintain compliance with rules governing this category of services.

Federal rules require states to assure health and safety for clients in all service settings, whether institutional or non-institutional. The rules also require that HCBS waiver services must be cost-effective.

In order to maintain a more accessible yet sustainable LT-PCS program, DHH has published guidelines to provide for a comprehensive assessment for each participant upon entry into the program to determine which of 23 categories of care is appropriate for the needs of the individual. The maximum number of hours of services per week was reduced from 56 to 42 in March 2009.

Reduction of excess costs is welcome wherever it is appropriate. However, an exceptionally long waiting list of almost 17,000 for the EDA waiver program must be addressed to assure needed care and provide equity. Safeguards must be in place to assure that persons who are able to live independently with proper supports and services are not unfairly institutionalized for lack of needed resources.

Agenda for change

Louisiana needs to pursue a strategy of improvement for its long-term care system that will achieve readily accessible, cost-effective and high-quality care in both institutional and non-institutional settings. Budgeting changes can enable a shift in resources that will accommodate a more efficient distribution of services across the continuum of care from institutional to home-based settings. Moreover, careful tracking and monitoring of the population as clients transition into and out of institutional care settings will facilitate a more ambitious approach to a better balanced system.

Recommendation 1: Reduce the 18,000-person waiting list for in-home and community-based care by redirecting $62 million generated by cost-

control measures into the Elderly and Disabled Adult (EDA) and the Adult Day Health Care (ADHC) waiver programs.

A cap on service hours provided in home and community-based settings might be a reasonable approach to cost containment, but should not be allowed to reverse recent gains in reducing the state's reliance on care provided in institutional settings. Louisiana has been moving in the right direction toward a more efficient system of care that enables elderly clients to live at home longer. Any savings realized from the proposed cap should be reinvested in non-institutional care. The budget should be adjusted to restore $62 million currently listed as budget cuts to fund program enrollment for persons on the EDA and ADHC waiting lists, starting with those who are current nursing home residents.

Although the Executive Budget adds $14 million for additional services, this amount only scratches the surface considering the size of the waiting list. Louisiana had the third largest waiting list in 2007 when there were only half as many persons applying for services (seeTable 3). Reducing the waiting list will allow many people to maintain their independence and avoid institutionalization, as well as provide some nursing home participants with the ability to live in their own homes. Based on recent average costs reported by DHH for the EDA and ADHC waivers, the proposed reinvestment of funds could reduce waiting lists by roughly 5,000 persons or about 28 percent.

Recommendation 2: Implement a tracking and reporting system that will ensure the state continues its shift toward a better balanced continuum of long-term care for the elderly that provides more home and community-based care options.

The in-home care service hour cap presents a potential risk that some participants will be forced to enter or re-enter nursing homes because they cannot access sufficient services in their homes. DHH indicates that it has been tracking clients in institutions as well as those living in the community and thus far has detected very limited movement of EDA waiver clients into nursing homes for the last several years. Nevertheless, the upcoming budget cuts in non-institutional care are of a magnitude that calls for stepped up monitoring by a wide range of stakeholders to ensure that persons who want to live independently continue to be provided the appropriate supports and services. Policymakers, legislators and the affected population should be provided with reports, preferably on a monthly basis, that will allow them to assess trends and potential problems in order to adopt remedial strategies if necessary.

Movement of clients among various programs, institutions and waiting lists should be routinely and carefully tracked to ensure early identification of unintended consequences of the new policy. The number of persons currently in nursing homes who have applied for in-home care and are on the waiting list also should be tracked on a monthly basis. DHH currently provides quarterly reports to the Legislature on the number of recipients and the costs of in-home and community-based care, but these reports are insufficient as tracking tools.

DHH routinely tracks long-term care clients with the aid of case managers but has no reporting system to communicate this information to policymakers and stakeholders. A report showing aggregate numbers of clients accessing various service or administrative categories would help to identify and measure broad trends throughout the long-term care system. At a minimum, DHH should report numbers of clients at major milestones in the long-term care process, including the following: initial placement on a waiting list; completion of initial needs assessment and individualized plan of care in consultation with client and family members; placement in appropriate care setting (nursing facility, in-home waiver services, in-home personal care services, adult day health care, etc.); changes in plan of care and setting; and discharge from the long-term care system. Additionally, a budget overview with spending and utilization history and projections should be provided.

Recommendation 3: Change the laws governing the use of the Elderly Trust Fund to allow interest earnings to be spent on services provided in nursing home and home-based settings.

The existing limitation on the use of Elderly Trust Fund dollars for nursing home care only is a barrier to progress and reinforces the state's historic preference for institutional care. By making the use of these dedicated funds more flexible, the Legislature can enable DHH to design a system that is more efficient, more responsive to client need and better able to reward good performance for both institutional and non-institutional providers.

Conclusion

The past few years have witnessed a seismic shift in long-term care for the elderly with the introduction of significant funding of home and community-based services. Clients who want to live independently and avoid or delay institutional care have demonstrated a high level of demand for these services. Today nearly 30 percent of long-term care spending is devoted to non-institutional care and it is likely to continue to grow as long as funding is not shifted to encourage re-institutionalization.

As in-home care service levels have grown, there has been only minimal movement toward closure of the growing number of empty nursing home beds. The long-term care system should be viewed as a continuum with nursing homes and in-home care occupying equally important but different roles according to the needs of the elderly population they serve.

Significant steps in the right direction can be achieved by correcting the budget for the next fiscal year and taking measures to reduce the waiting list for in-home care.

Primary author of this research brief is David W. Hood, Senior Healthcare Policy Research Analyst.

For more information, go to www.la-par.org.

Each report in PAR's ongoing health care policy research series is available online.

GLOSSARY

HOME AND COMMUNITY-BASED WAIVERS – Federal law permits states to offer, by waiving certain federal requirements, a wide array of Medicaid home and community-based services that an individual may need to avoid institutionalization. Services include case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care and other services. The aggregate cost of services for waiver clients cannot exceed the aggregate cost of services provided in an institutional setting.

ELDERLY AND DISABLED (EDA) ADULT WAIVER – The EDA waiver provides certain in-home and community-based services to elderly or disabled adults who qualify. Participants must meet the following criteria: (a) meet Medicaid financial eligibility, (b) be age 65 or older OR be 21 or older with a disability that meets federal definition, and (c) must meet nursing facility level-of-care requirements. Approximately 70 percent of participants are elderly and 30 percent are non-elderly adults with disabilities. Services include case management, support services for transition from nursing facilities and adult day health care services.

LONG-TERM PERSONAL CARE SERVICES (LT-PCS) – LT-PCS is a Medicaid state plan service, rather than a home and community-based waiver. The program provides assistance with eating, bathing, dressing, walking, toileting, light housekeeping, laundry and other activities of daily living (ADLs). Participants must meet the following criteria: (a) meet Medicaid financial eligibility, (b) be age 65 or older OR be 21 or older with a disability that meets federal definition, and (c) must meet nursing facility level-of-care requirements AND require at least limited assistance with one or more ADLs. Participation in the program also requires that a person would have to enter a nursing facility within 120 days if LT-PCS were not provided OR a person could be discharged from a nursing facility if LT-PCS were available to them. Approximately 65 percent of participants are elderly and 35 percent are non-elderly with disabilities.

ELDERLY TRUST FUND – The Elderly Trust Fund was established by the Legislature in 2000 and currently has approximately $760 million in total assets which are invested by the State Treasurer in accordance with guidelines set forth in state law. Interest earnings from the fund are used to pay for certain expenses of nursing facilities, including funding of the case mix reimbursement system established in 2003, payment for adjustments to payment rates for nursing facilities and wage enhancements for facility personnel. ETF funds are provided for the initial year of funding the above requirements and are replaced with state general fund appropriations in succeeding years.

The Public Affairs Research Council (PAR) is a private, nonprofit, non-partisan public policy research organization focused on pointing the way toward a more efficient, effective, transparent and accountable Louisiana government. PAR was founded in 1950 and is a 501(c)(3) tax-exempt organization supported by foundation and corporate grants and individual donations. PAR has never accepted state government funds.

Public Affairs Research Council of Louisiana
4664 Jamestown Ave., Suite 300
Baton Rouge, LA 70808
Phone: (225) 926-8414
www.la-par.org

Jim Brandt, *President*
jimbrandt@la-par.org

Jennifer Pike, *Research Director*
jpike@la-par.org

David Hood, *Senior Healthcare Policy Analyst*
dwhood@la-par.org