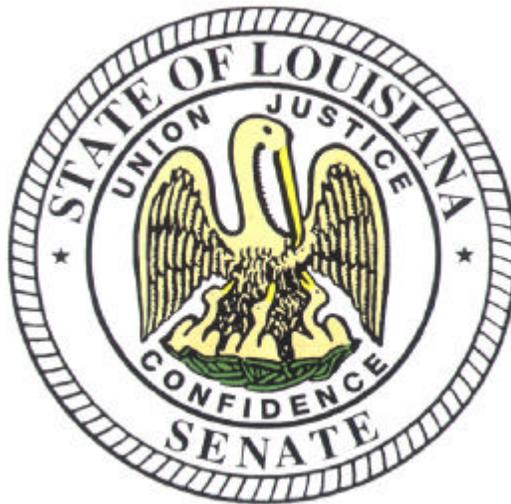

SENATE FOCUS FORUM

Health\Social Services Program Summary Tickfaw State Park

Final



November, 2000

The Honorable John J. Hainkel
President of the Senate

Prepared and Compiled by Senate Staff

NURSING HOMES AND HOME HEALTH IN THE STATE

According to Wendy Fox-Grage, Senior Policy Specialist, Forum for State Health Policy Leadership, National Conference of State Legislatures, Louisiana has too many nursing homes beds for its population and suggested that, like most other states, Louisiana should be moving toward offering additional choices to its citizens in order to contain growth in long term care costs and to address a recent United States Supreme Court decision (Olmstead) holding that the American with Disabilities Act (ADA) requires states to provide community based services to institutionalized persons in certain circumstances. While Ms Fox-Grage did not suggest in any way that Louisiana discontinue utilizing nursing homes for its Medicaid recipients, she did recommend that the state establish a plan for a continuum of care to serve people in the most appropriate settings with a stronger emphasis on more home and community-based care, family caregiving, and long term care insurance.

In 1998, Louisiana had a total population of 4,361,447 with 523,704 ages 65 and over. In 1998, Louisiana also had 365 nursing home facilities and 29,829 nursing home beds. Long term care services were provided to 34,403 Medicaid nursing home recipients at a cost of \$490.7 million or \$14,263 per recipient. This cost represented the largest category of expenditures in the Medicaid budget. To control cost for nursing home care, Ms Fox-Grage pointed out that many other states have implemented certain requirements including: tightening medical eligibility, mandatory pre-admission screening, client assessment, referral, and evaluations, moratoriums on additional beds, and case mix reimbursement based on a resident's needs instead of a flat rate for all residents. Louisiana currently has a moratorium on new nursing home beds and will implement a case mix reimbursement system for nursing homes as provided by Act No. 143 of the First Extraordinary Session, 2000.

Many states are already moving forward in providing alternatives to nursing home care and are establishing assisted living programs and other home and community-based care programs through Medicaid waivers. In fact, the Office of Civil Rights (OCR) of the United States Department of Health and Human Services has strongly suggested that state Medicaid programs should develop a plan to increase community based services in order to comply with Olmstead. Due to budget restraints, the Department of Health and Hospitals (DHH) currently provides only limited community-based care waiver programs including:

- Elderly & Adult with Disabilities (serving 629 people)
- Adult Day HealthCare (serving 500 people)
- Personal Care Attendant (serving 124 people)

and has been unable to implement the assisted living pilot programs for the elderly as established by Act No. 1185 of the 1997 Regular Session. DHH will include in its budget request for FY 2001 funding for additional waiver slots for each of these waiver programs and funding for the assisted living program in an attempts to comply with Olmstead and to settle Barthelme vs Hood, a federal class action suit filed alleging that Louisiana's Medicaid program violates the ADA because it provides predominantly institutional care (nursing home) and insufficient community-based services.

Family caregiving should also be encouraged for those citizens in the state who need long-term care services. Statistics indicate that 78% of long-term care services are provided by families and friends. California, Pennsylvania, and New Jersey have implemented comprehensive programs, and Florida has a RELIEF program. With additional funding Louisiana would be able to expand its adult day health care services and attendant care at home.

Louisiana must make a commitment to help meet the long term care needs of its citizens in the most appropriate settings and must make every effort to help provide resources and services in an effective and cost efficient manner. It will require planning, setting priorities, and evaluating existing approaches to long term care with some restructuring and shifting of resources from nursing homes to home and community-based care alternatives. As is the case with most enhancement and policy shifting in a new direction, the issue of funding always becomes the critical roadblock no matter how dedicated a state may be to the new concept. Regarding funding, for once Louisiana may actually have the possibility of obtaining new funds with passage of Act No. 143 of the First Extraordinary Session 2000, which established the Medicaid Trust Fund for the Elderly (intergovernmental transfer program). At present, it is estimated that Louisiana may receive two full years of funding from the federal government before the intergovernmental transfer program is revamped. During these two years Louisiana could receive approximately \$800 million to \$1 billion which would be placed in the trust fund in the state treasury. This trust fund could potentially generate between \$60-85 million of interest that would then be used to obtain federal matching funds each year totaling approximately \$200-\$250 million for Medicaid programs. The Act mandates several priorities including: case mix reimbursement, re-basing, and enhancement to labor cost in Louisiana's nursing home industry. Total projected cost for these priorities is approximately \$75-85 million annually, leaving approximately \$125-175 million available for other Medicaid expenditures. However, expenditures over and above the priorities do have certain restrictions.

PRESCRIPTION DRUG ISSUES IN THE STATES

Louisiana Trends in Medicaid Pharmaceutical Spending

1. Medicaid's pharmacy program has grown from \$85 million in FY 89 to \$444 million in FY 01
2. Louisiana's average Medicaid pharmacy cost per recipient ranked fifth (5th) in the South in FY 99
3. Louisiana's Medicaid pharmacy program could reach \$925 million in FY 05

Key Reasons for the Growth in Pharmaceutical Expenditures in Louisiana and U.S.

1. Quicker FDA approval
2. Growing utilization of pharmaceuticals due to:
 - rising number of prescriptions filled by retail and mail-order pharmacies
 - pharmaceuticals replacing surgery and other more invasive treatments
 - pharmaceuticals offering therapies not available in the past
 - greater consumer awareness of drug treatments due in part to direct advertising
3. Increasing prices for newer, more expensive brand name, generic, and multi-source drugs
4. Drug manufacturer rebate programs
5. Medicaid's open drug formulary
 - requires Medicaid reimbursement of all FDA-approved drugs
 - prohibits use of prior authorization options

Possible Louisiana Options to Curtail the Growth in Pharmaceutical Expenditures

1. Delay inclusion of FDA-approved drugs into Medicaid's open drug formulary
 - increased formulary restrictions may backfire, however, resulting in more office visits, more ER visits, and more hospitalizations
2. Allow for generic substitutions in treating Medicaid recipients
3. Allow the use of prior authorization option in the Medicaid program

4. Achieve **better profiling of doctors** who may be abusing their Medicaid prescription-writing privileges
5. Implement a **three-tiered co-payment structure** that attempts to shift more costs to the consumer by charging the Medicaid patient:
 - the lowest price for a generic drug
 - a higher price for a brand-name drug when no generic version is available
 - a significantly higher price for a brand-name drug when a generic version is available
6. Reap savings by **purchasing drugs in bulk** through the state for:
 - seniors who do not have drug coverage (perhaps focusing on seniors with catastrophic drug expenses)
 - medicaid and Medicare beneficiaries
 - state employees
 - state residents without insurance coverage for drugs
7. Authorize **price controls**, using the state=s power to lower drug prices by authorizing the state to:
 - act as a pharmacy benefit manager
 - negotiate pharmaceutical prices with manufacturers
 - purchase drugs at a discount for the residents it wants to cover (see No. 6 above)
 - set maximum prices for prescription drugs

(Note that price controls over time could have the negative consequence of reducing the availability of certain drugs)

8. Allow for the **purchase of drugs from foreign countries** where they are cheaper
9. Enact legislation allowing for **private drug buying co-ops and purchasing clubs** to be regulated by the state
10. Enact legislation allowing for **collaborative practices** to allow physicians to prescribe a drug protocol and allow pharmacists to fill prescriptions with the most cost-effective pharmaceutical in that class or to make adjustments as necessary