GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Louisiana, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2025

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Louisiana, USA

In-Kind Benefits

Plan details 1992-2025 * †

Public long-term care (LTC) benefits in Louisiana are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Louisiana, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, Louisiana's Medicaid LTC system has been subject to 2 major policy reforms: the implementation of a new state plan personal care services benefit in 2004, and the implementation of a new home and community-based services program in 2011.

Key Dates

First law: 1965

Major changes since 1992: 2004, 2011

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* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

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Chapter 1: Policy enacted 1992-2003

Overview

Long-term care (LTC) benefits in Louisiana are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Louisiana is administered at the state level by the Louisiana Department of Health and Hospitals, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Louisiana are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Elderly and Disabled Adult).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Elderly and Disabled Adult program are able to receive a variety of LTC benefits if deemed medically eligible, such as personal supervision services and personal attendant services. Those applying for the Elderly and Disabled Adult program are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and Elderly and Disabled Adult program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Policy changes during this period:

- (1993) From January 15, nursing facility residents could spend down their income in order to qualify for Medicaid. This is referred to as eligibility track 3a (Medically Needy—Aged, Blind, or Disabled) (LR, 1993b, p. 14).
- (1993) Effective April 1, Louisiana implemented a Home Care for the Elderly program providing HCBS to individuals age 65 and over (LR, 1993a, p. 438).
- (1995) Louisiana implemented an estate recovery program to recover Medicaid payments for nursing facility services, HCBS, and related hospital and prescription drug services paid on behalf of a Medicaid enrollee (DHH, 1999).
- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration (US Congress, 1996).
- (1997) Effective April 1, the Home Care for the Elderly program was renamed the Elderly and Disabled Adult program and its target population was expanded to include disabled adults age 21-64 (DHH, 1999).
- (2002) Waiting lists maintained by each of the state's 64 parish Councils on Aging were consolidated into one statewide waiting list maintained by the Louisiana Department of Health and Hospitals (DHH) (LR, 2002a, p. 835).
- (2003) In December the DHH removed the homebound requirement for home health service eligibility (LR, 2003a, p. 2907).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2025b)

Louisiana Law for Medicaid

- Louisiana Administrative Code Title 50. Public Health—Medical Assistance (LDA, 2025)
  - Part II. Nursing Facilities
  - Part III. Eligibility
  - Part XIII. Home Health Program
  - Part XV. Services for Special Populations
  - Part XXI. Home and Community-Based Services Waivers

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Louisiana Medicaid spending on beneficiaries in fiscal year 1992 was 75.44%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Louisiana Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Louisiana.

Eligibility for Medicaid in Louisiana for people needing LTC services is primarily attained by satisfying at least 1 of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount (CMS, 2004a).[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (CMS, 2004b). This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be a Louisiana resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a U.S. citizen or qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (CMS, 2004a). In 1992 this was $1,266 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled Adult program and has a spouse residing in the community.[5] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Resources may not exceed $2,000 for an individual (CMS, 2004b). Income for this track is evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled Adult program and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards.
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a home or community-based LTC program (e.g., Elderly and Disabled Adult program).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled —January 1993–June 1996 and July 1997–present[7]
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to be equal to or less than the Medically Needy Income Eligibility Standard (MNIES). Louisiana's MNIES varies by region, with parishes grouped into urban and rural areas. In 1992, the MNIES for rural regions is $92 per month for an individual and $167 per month for a couple. The MNIES for the 4 urban parishes (East Baton Rouge, Jefferson, Orleans, and St. Bernard Parishes) is $100 per month for an individual and $192 per month for a couple (CMS, 2004a; LDH, 2020). Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled Adult program and has a spouse residing in the community.[5]
  - Asset requirements: Same asset requirements as eligibility track 1a (CMS, 2004b).
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Elderly and Disabled Adult

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65. From April 1, 1997, the age limit was expanded to include disabled adults age 21-64 (DHH, 1998; LR, 1998, p. 42). If the program reaches enrollment capacity, the applicant is placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care (ADHC) program
- Assisted Living program—from 1997
- Personal Care Attendant program

Benefit

Home care benefit

Home care benefits vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

Home health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are limited to 50 visits per year (LR, 2002b, p.1093; CMS, 2004c).

Nursing Facility Care

Nursing facility care does not provide home care.

Elderly and Disabled Adult

The Elderly and Disabled Adult program provides the following home care services (LR, 1998, p. 42):

- Homemaker services: Referred to as Household Supports in Louisiana, homemaker services provide general household activities and chores essential to the beneficiary's care (e.g., personal laundry, meal preparation, having prescriptions filled)
- Personal care services (PCS): Referred to as Personal Care Attendant services during this policy period, PCS provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility

Community care

Community care benefits vary by health benefit program. The details of the 3 largest programs (Home Health Services, Nursing Facility Care, Elderly and Disabled Adult) do not provide this type of care, but smaller programs may.

Residential care

Residential care benefits vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services, Elderly and Disabled Adult

These programs do not provide residential care.

Nursing Facility Care

Louisiana Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs. Services may include the following (CMS, 2002; LAC 50:II §§10117-10141, 2025):

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by health benefit program. Below we detail other benefits provided by Medicaid state plan benefit programs (Home Health Services, Nursing Facility Care), followed by Louisiana's largest home and community-based services (HCBS) program.

Louisiana Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Elderly and Disabled Adult

The Elderly and Disabled Adult program provides the following services in addition to those offered under the state plan, unless otherwise noted (LR, 1998, p. 42):

- Personal Supervision (day): Non-medical care, supervision, and socialization provided to a functionally impaired adult, which can include homemaker services such as meal preparation or laundry but not as discrete services as provided by a trained household support worker
- Personal Supervision (night): Non-medical care, supervision, and socialization provided for the safety of individuals with limited mobility or cognitive function who cannot preserve their own safety in dangerous situations

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Louisiana Department of Health and Hospitals (DHH). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by registered nurses, and home health aide services are provided by home health aides employed by state-certified home health agencies. Home health aide services are provided under the direction of a registered nurse (LR, 2002b, p. 1094; LAC 50:XIII §§ 101-105, 2025).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (42 CFR 483.30).

Elderly and Disabled Adult

Elderly and Disabled Adult program services are provided by authorized staff of state-approved personal attendant provider agencies (DHH, 2001; LR, 2004a, p. 1699).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 3 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. The beneficiary must also be homebound, which requires that the beneficiary be unable to leave home without considerable effort, doing so infrequently and briefly or for necessary medical services (LR, 2002, p. 1093; LR, 2004b, 430). The Louisiana Department of Health and Hospitals (DHH) removed the homebound requirement in 2003 (LR, 2003a, p. 2907).

Nursing Facility Care

Beneficiaries must meet a nursing facility level of care (NFLOC) by having a physician certify the medical necessity of their nursing home placement (LR, 1997, p. 1317).

Elderly and Disabled Adult

Beneficiaries must meet an NFLOC by having a physician certify that they would qualify for nursing facility care if not for the receipt of program services (LR 1998, p. 42).

Duration of benefit

Reassessments of eligibility vary by health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the 3 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (LR, 2002b, 1093, LAC 50:XIII § 103, 2025).

Nursing Facility Care

Nursing facility level of care (NFLOC) must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities. After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20; 42 CFR 483.128).

Elderly and Disabled Adult

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (LAC 50:XII § 8107, 2025).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 3 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Elderly and Disabled Adult

The individual must be at least age 65, or 21-64 and disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. Until 2004 the beneficiary must also be homebound, which requires the beneficiary to satisfy the following 3 conditions (LR, 1996b, p. 218):

- The beneficiary is typically unable to leave the home
- The beneficiary is unable to leave the home without experiencing considerable and taxing effort
- The beneficiary's absences from home are infrequent, of short nature, or to receive medical services which are unavailable in the home setting

Nursing Facility Care, Elderly and Disabled Adult

Beneficiaries must meet a nursing facility level of care (NFLOC) by having a physician certify that they require the level of care normally provided in a nursing home using Request for Level of Care Determination Form 90-L. There are no objective criteria to satisfy an NFLOC during this policy period (LLA, 2005).

Evaluation of dependence

Evaluations of dependence vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services in accordance with a plan of care that establishes medical need. Services must be authorized in advance, and the beneficiary must be seen by a physician at least every 60 days to recertify their continuing need for home health services (LR, 2002b, p. 1093).

Nursing Facility Care

Three forms are submitted to the Louisiana Department of Health and Hospitals (DHH) within 20 days of nursing facility admission: Notice of Admission or Change Form 148 verifying the individual's admission as a Medicaid, Medicare, or private pay resident; Form Request for Medical Eligibility Determination Form 90-L certifying that the individual requires a nursing facility level of care (NFLOC); and the federally required Preadmission Screening and Resident Review (PASRR) certifying that the individual does not require specialized care for a mental illness or intellectual disability (LLA, 2005; LR, 1997, p. 1317).

While there are no standardized assessment criteria to determine NFLOC during this policy period, form 90-L collects information on ADLs, mental status, behavioral issues, medications, and specialized services received (e.g., ostomy care, dialysis, and diet/tube feeding) in order to justify the physician-certified NFLOC designation. After the initial admission process, the beneficiary's functional limitations and care needs are assessed periodically using the federally mandated Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for more information on the MDS.

Elderly and Disabled Adult

Individuals must first contact their local Council on Aging to be placed on a waiting list maintained by each parish, and are contacted by a local intake office for evaluation once a program slot becomes available. In 2002 the 64 parish waiting lists were consolidated into one statewide waiting list administered by the DHH (LR, 2002a, p. 835). Case managers assist in collecting the documentation required for program entry, including Form 90-L certifying that the individual requires an NFLOC, which is submitted along with supporting documentation to the DHH for prior authorization of services. Once an individual is certified as eligible for program services, a comprehensive assessment of the beneficiary's functional limitations and care needs is conducted using the Minimum Data Set for Home Care (MDS-HC) in order to build the beneficiary's plan of care (LR, 1998, p. 42; LLA, 2005). The MDS-HC collects information on a range of functional and cognitive limitations including activities of daily living (ADLs), cognitive abilities, behavioral issues, communication patterns, mood, vision, and social supports (DHH, 2010).

Evaluators

Evaluators vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop a written plan of care, and periodically review the plan of care (LR, 2002b, p. 1093).

Nursing Facility Care

A licensed physician must certify the beneficiary's need for nursing facility care using screening form 90-L. Periodic assessments using the Minimum Data Set (MDS) are conducted or coordinated by a registered nurse (LR, 1997, p. 1317).

Elderly and Disabled Adult

A licensed physician must certify that the beneficiary meets an NFLOC using form 90-L, and must order services by developing a plan of care. These documents are submitted to the DHH for final approval to determine eligibility for program services (LR, 1998, p. 42).

Benefit limitations

Can you mix LTC benefits?

All Louisiana Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 3 largest programs.

Medicaid

In 1995, Louisiana implemented an estate recovery program as required by federal law (DHH, 1999; LR, 1996a, p. 50). The acceptance of Medicaid in Louisiana creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility care, or for the receipt of HCBS program services after the recipient reaches 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services

Available Louisiana state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 1992, the PNA in Louisiana is $38 (SSA, 2011; LDH, 2025c).

Elderly and Disabled Adult

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2004-2010

Policy change in 2004
Effective January 1, 2004, Louisiana began offering personal care services (PCS) as a state plan benefit referred to as the Long Term Personal Care Services (LT-PCS) program (LR, 2003b, p. 911, CMS, 2003; DHH, 2005). LT-PCS replaced an existing personal care attendant program, which had a low enrollment cap. In order to avoid duplication in services, personal care services were removed from the Elderly and Disabled Adult program by 2006 (LR, 2006a, p. 1245).

Other policy changes during this period:

- (2006) Effective December 1, Louisiana implemented the Level of Care Eligibility Tool (LOCET) to standardize eligibility criteria for programs requiring a nursing facility level of care (NFLOC) (LR 2006c, p. 2083).
- (2006) A new benefit package was offered under the Elderly and Disabled Adult program. Household supports and personal care attendant services were eliminated, personal supervision was renamed companion services, and new benefits such as transition services and environmental accessibility adaptations were made available to program enrollees (LR 2006a, p. 1245).
- (2007) Louisiana implemented a home equity limit that made individuals with home equity above $500,000 ineligible for LTC (LDH, 2025a).
- (2008) Adult day health care (ADHC) was added as an Elderly and Disabled Adult program benefit (LR 2008, p. 1031).
- (2009) Effective March 1, LT-PCS are limited to a maximum of 42 service hours per week (CMS, 2009).
- (2009) Effective July 1, the Louisiana Personal Options Program (La POP) was implemented to allow LT-PCS recipients to hire and manage the personal care services provider of their choice (CMS, 2010). This is often referred to as consumer-directed care.
- (2010) Effective July 1, the Elderly and Disabled Adult program replaced companion services, a benefit providing primarily supervision, with personal attendant services which provides a broader set of personal care services (PCS) to assist individuals with their care needs (DHH, 2011).
- (2010) Effective September 5, LT-PCS are limited to a maximum of 32 service hours per week (CMS, 2017).

Overview

Long-term care (LTC) benefits in Louisiana are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Louisiana is administered at the state level by the Louisiana Department of Health and Hospitals, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Louisiana are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care, Long Term Personal Care Services—LT-PCS), or through federally approved home-and community-based services (HCBS) LTC programs (Elderly and Disabled Adult).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services and LT-PCS provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Elderly and Disabled Adult program are able to receive a variety of LTC benefits if deemed medically eligible, such as companion services and environmental accessibility adaptation. Those applying for the Elderly and Disabled Adult program are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility, and Elderly and Disabled Adult, and LT-PCS program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2025b)

Louisiana Law for Medicaid

- Louisiana Administrative Code Title 50. Public Health—Medical Assistance (LDA, 2025)
  - Part II. Nursing Facilities

- Part III. Eligibility
- Part XIII. Home Health Program
- Part XV. Services for Special Populations
- Part XXI. Home and Community-Based Services Waivers

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Louisiana Medicaid spending on beneficiaries in fiscal year 2004 was 73.84%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Louisiana Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Louisiana.

Eligibility for Medicaid in Louisiana for people needing LTC services is primarily attained by satisfying at least 1 of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount (CMS, 2004a).[1] In 2004, the monthly federal benefit amount was $564 for an individual and $846 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (CMS, 2004b). This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[8]
    - Home equity limit: From 2007, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services. See Table 4 for historical home equity limits.[9]
  - Citizenship/immigration requirements: The applicant must be a Louisiana resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration

and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024) for additional information.

- ◇ Other requirements
  - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (CMS, 2004a). In 2006 this was $1,692 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled Adult program and has a spouse residing in the community.[10] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual (CMS, 2004b). Income for this track is evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled Adult program and has a spouse residing in the community.[11] See Table 3 for historical monthly spousal disregards.
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a home or community-based LTC program (e.g., Elderly and Disabled Adult program).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - ◇ Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to be equal to or less than the Medically Needy Income Eligibility Standard (MNIES). Louisiana's MNIES varies by region, with parishes grouped into urban and rural areas. In 2004, the MNIES for rural regions is $92 per month for an individual and $167 per month for a couple. The MNIES for the 4 urban parishes (East Baton Rouge, Jefferson, Orleans, and St. Bernard Parishes) is $100 per month for an individual and $192 per month for a couple (CMS, 2004a; LDH, 2020). These standards have remained the same since 1992. Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled Adult program and has a spouse residing in the community.[5]
  - ◇ Asset requirements: Same asset requirements as eligibility track 1a (CMS, 2004b).
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Elderly and Disabled Adult

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 or age 21-64 and disabled (DHH, 1998; LR, 1998, p. 42). If the program reaches enrollment capacity, the applicant is placed on a waiting list until a spot becomes available.

LT-PCS

Applicants must be at least age 65 or age 21-64 and disabled (DHH, 2009).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care (ADHC) program
- Assisted Living program
- Personal Care Attendant program—until 2004
- Program of All-Inclusive Care for the Elderly (PACE)—from 2007

Benefit

Home care benefit

Home care benefits vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services

Home health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are limited to 50 visits per year (CMS, 2004c).

Nursing Facility Care

Nursing facility care does not provide home care.

Elderly and Disabled Adult

The Elderly and Disabled Adult program provides the following home care services (LR, 1998, p. 42):

- Homemaker services: Referred to as Household Supports in Louisiana, homemaker services provide general household activities and chores essential to the beneficiary's care (e.g., personal laundry, meal preparation, having prescriptions filled)
- Personal care services (PCS): Referred to as Personal Care Attendant services during this policy period, PCS provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility

From 2006 the Elderly and Disabled Adult program removed its homemaker services and PCS benefits, replacing them with companion services that provide supervision, socialization (during the day or night), and care to individuals with functional impairments who are unable to direct their own care or stay safely alone (LR, 2009, p. 2448).

LT-PCS

LT-PCS provides:

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

LT-PCS visits are limited to 56 hours per week (CMS, 2003). The weekly visit cap was further limited to 42 hours per week in 2009, and to 32 hours per week in 2010 (CMS, 2009; CMS, 2017).

Community care

Community care benefits vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services, Nursing Facility Care, LT-PCS

These programs do not provide community care.

Elderly and Disabled Adult

From 2008 the Elderly and Disabled Adult program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (LR, 2008, p. 1031).

Residential care

Residential care benefits vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services, Elderly and Disabled Adult, LT-PCS

These programs do not provide residential care.

Nursing Facility Care

Louisiana Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs. Services may include the following (CMS, 2002; LAC 50:II §§10117-10141, 2025):

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by health benefit program. Below we detail other benefits provided by Medicaid state plan benefit programs (Home Health Services, Nursing Facility Care, LT-PCS), followed by Louisiana's largest home and community-based services (HCBS) program.

Louisiana Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Elderly and Disabled Adult

The Elderly and Disabled Adult program provides the following services in addition to those offered under the state plan, unless otherwise noted (LR, 1998, p. 42):

- Personal supervision (day): Non-medical care, supervision, and socialization provided to a functionally impaired adult, which can include homemaker services such as meal preparation or laundry but not as discrete services as provided by a trained household support worker
- Personal supervision (night): Non-medical care, supervision, and socialization provided for the safety of individuals with limited mobility or cognitive function who cannot preserve their own safety in dangerous situations

From 2006 night and day personal supervision services were combined into one companion services benefit, and the following services were added to the program benefits package (LR, 2006, p. 1245):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care, referred to in Louisiana as "Support coordination"
- Personal emergency response system (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., financial support for moving expenses)
- Transition intensive support coordination: Case management services for nursing facility residents seeking to transition back to a home and community-based setting
- Environmental accessibility adaptation: Necessary physical adaptations made to the home to ensure the health, safety, welfare, and independent functioning of the recipient

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Louisiana Department of Health and Hospitals (DHH). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by registered nurses, and home health aide services are provided by home health aides employed by state-certified home health agencies. Home health aide services are provided under the direction of a registered nurse (LR, 2002b, p. 1094; LAC 50:XIII §§ 101-105, 2025).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (LAC 50:II § 10121, 2025, 42 CFR 483.30).

Elderly and Disabled Adult

Elderly and Disabled Adult program services are provided by authorized staff of state-approved personal care attendant provider agencies, and are coordinated by trained staff of support coordination agencies (LR, 2006a, p. 1245; DHH, 2006).

LT-PCS

Personal care services are provided by licensed personal care workers employed by state-certified personal care attendant agencies (LR, 2003b, p. 913, LAC 50:XV § 12909, 2025).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 4 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury (LR, 2004b, p. 431).

Nursing Facility Care

Beneficiaries must meet a nursing facility level of care (NFLOC) by having a physician certify the medical necessity of their nursing home placement (LR, 1997, p. 1317). From 2006, beneficiaries meet an NFLOC by satisfying 1 of 7 eligibility pathways on the Level of Care Eligibility Tool (LOCET) (LR, 2006d, p. 2084).

Elderly and Disabled Adult

Beneficiaries must meet an NFLOC by having a physician certify that they would qualify for nursing facility care if not for the receipt of program services (LR 1998, p. 42). From 2006, beneficiaries meet an NFLOC by satisfying 1 of 7 eligibility pathways on the LOCET (LR, 2006a, p. 1245; LR, 2006d, p. 2084).

LT-PCS

Personal care services must be medically necessary and prior authorized by the Louisiana Department of Health and Hospitals (DHH). Personal care services are medically necessary if the beneficiary meets an NFLOC and if they are able to direct the services of a personal care worker either independently or through a designated representative (LR, 2006a, p. 2082). From 2006, beneficiaries meet an NFLOC by satisfying 1 of 7 eligibility pathways on the Level of Care Eligibility Tool (LOCET) (LR, 2006d, p. 2084).

Duration of benefit

Reassessments of eligibility vary by health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the 4 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (LR, 2002b, 1093, LAC 50:XIII § 103, 2025).

Nursing Facility Care

Nursing facility level of care (NFLOC) must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities. After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20; 42 CFR 483.128).

Elderly and Disabled Adult, LT-PCS

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (LDHH, 2009; LAC 50:XII § 8107, 2025).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 4 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Elderly and Disabled Adult, LT-PCS

The individual must be at least age 65, or 21-64 and disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury (LAC 50:XIII § 103, 2025).

Nursing Facility Care, Elderly and Disabled Adult, LT-PCS

Prior to the implementation of the Level of Care Eligibility Tool (LOCET) there were no objective criteria used by physicians to certify that beneficiaries met a nursing facility level of care (NFLOC). From 2006, beneficiaries meet an NFLOC by satisfying 1 of 7 eligibility pathways as assessed on the LOCET. The 7 pathways are (LR 2006c, p. 2083; LR 2011, p. 342):

- Activities of Daily Living (ADLs) Pathway: The beneficiary must require at least extensive assistance in eating, or at least limited assistance in either toilet use, transferring, or bed mobility
- Cognitive Performance Pathway: Identifies beneficiaries with cognitive difficulties in short-term memory, daily decision making, and making oneself understood
- Physician Involvement Pathway: Within the last 14 days, the beneficiary must have had at least 1 doctor visit with 4 order changes or more, or at least 2 days of doctor visits with 2 order changes or more
- Treatments and Conditions Pathway: The beneficiary must have at least 1 of 9 medical treatments or conditions over the past 7-14 days
- Skilled Rehabilitation Therapies Pathway: The beneficiary must have received within the prior week, or be scheduled to receive within the following week, at least 45 minutes of active physical, occupational, and/or speech therapy
- Behavior Pathway: The beneficiary must have exhibited at least 1 listed behavior on at least 4-6 out of the prior 7 days —these include wandering, verbally abusive behavior, physically abusive behavior, socially inappropriate or disruptive behavior, and resisting care
- Service Dependency Pathway: This pathway is for beneficiaries who currently receive LT-PCS, nursing facility, or Elderly and Disabled Adult program services that were initially approved prior to the December 1, 2006 implementation of the LOCET, and for whom ongoing services are required to maintain their current functional status

For more information on the eligibility thresholds required to satisfy each pathway see Box 3 for pathways 1 through 4, and Box 4 for pathways 5 through 7.

Evaluation of dependence

Evaluations of dependence vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services in accordance with a plan of care that establishes medical need. Services must be authorized in advance, and the beneficiary must be seen by a physician at least every 60 days to recertify their continuing need for home health services (LR, 2002b, p. 1093).

Nursing Facility Care

Three forms are submitted to the Louisiana Department of Health and Hospitals (DHH) within 20 days of nursing facility admission: Notice of Admission or Change Form 148 verifying the individual's admission as a Medicaid, Medicare, or private pay resident; Form Request for Medical Eligibility Determination Form 90-L certifying that the individual requires a nursing facility level of care (NFLOC); and the federally required Preadmission Screening and Resident Review (PASRR) certifying that the individual does not require specialized care for a mental illness or intellectual disability (LLA, 2005; LR, 1997, p. 1317).

From 2006, two forms are submitted to the Louisiana Department of Health and Hospitals (DHH) within 20 days of nursing facility admission: a Level of Care Eligibility Tool (LOCET) assessment certifying that the individual meets an NFLOC, and the PASRR screening. After the initial admission process, the beneficiary's functional limitations and care needs are assessed periodically using the federally mandated Minimum Data Set (MDS) (LR, 2006d, p. 2085; LAC 50:II § 503, 2025). For more information on LOCET eligibility thresholds see Box 3 for pathways 1 through 4, and Box 4 for pathways 5 through 7. See Box 1 for more information on the PASRR, and Box 2 for more information on the MDS.

Elderly and Disabled Adult

Individuals must first contact the DHH to be placed on a Request for Services Registry, a statewide waitlist for program slots maintained by the department. Prior to 2006, NFLOC was authorized through a physician's certification that was confirmed by the DHH prior to the authorization of services. From 2006, individuals are screened using the LOCET to determine whether they meet an NFLOC and satisfy other age or disability-related criteria for program entry before their names are added to the registry waitlist. For more information on LOCET eligibility thresholds see Box 3 for pathways 1 through 4, Box 4 for pathways 5 through 7, and (DHH, 2010) for a copy of the LOCET assessment tool. Once a slot becomes available, a comprehensive assessment of the beneficiary's functional limitations and care needs is conducted using the Minimum Data Set for Home Care (MDS-HC) in order to build the beneficiary's plan of care (LR, 2004a, p. 1699; LAC 50:XXI § 8103, 2025). The MDS-HC collects information on a range of functional and cognitive limitations including ADLs, cognitive abilities, behavioral issues, communication patterns, mood, vision, and social supports (DHH, 2010).

LT-PCS

Prior to 2006, NFLOC was certified using Request for Medical Eligibility Determination Form 90-L, which collects information on ADLs, mental status, behavioral issues, medications, and specialized services received (e.g., ostomy care, dialysis, and diet/tube feeding) in order to justify the physician-certified NFLOC designation. Form 90-L is submitted along with supporting documentation to the DHH for prior authorization. Once LT-PCS services have been authorized, a full assessment is conducted using the MDS-HC to identify long-term care needs and build the beneficiary's plan of care (DHH, 2004; LR, 2004c, p. 2831).

After 2006 NFLOC is certified using the Level of Care Eligibility Tool (LOCET). The LOCET collects information on ADL limitations, cognitive performance, behavioral issues, physician's orders, medical treatments, and skilled rehabilitative therapies in order to determine whether the individual qualifies through 1 of 7 eligibility pathways. For more information on LOCET eligibility thresholds see Box 3 for pathways 1 through 4, Box 4 for pathways 5 through 7, and (DHH, 2010) for a copy of the LOCET assessment tool. Once NFLOC criteria have been met the beneficiary is assessed using the MDS-HC to identify long-term care needs and build their plan of care (DHH, 2009, 30.5; LR, 2013, p. 2506).

Evaluators

Evaluators vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop a written plan of care, and periodically review the plan of care (LR, 2002b, p. 1093, LAC 50:XIII § 103, 2025).

Nursing Facility Care

A licensed physician must certify the beneficiary's need for nursing facility care, and periodic assessments using the Minimum Data Set (MDS) are conducted or coordinated by a registered nurse (LR, 2006d, p. 2085, LAC 50:II § 503, 2025).

Elderly and Disabled Adult

A licensed physician must certify that the beneficiary meets an NFLOC, and must order services by developing a plan of care. These documents are submitted to the DHH for final approval to determine eligibility for program services (LR, 1998, p. 42, LAC 50:XXI § 8103, 2025).

LT-PCS

Personal care services must be authorized by the provider agency in a plan of care that is submitted to the Louisiana Department of Health and Hospitals (DHH) for final approval (LR, 2003b, p. 911, LAC 50:XV § 12901, 2025).

Benefit limitations

Can you mix LTC benefits?

All Louisiana Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 4 largest programs.

Medicaid

As required by federal law, Louisiana enforces Estate Recovery. The acceptance of Medicaid in Louisiana creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility care, or for the receipt of HCBS program services after the recipient reaches 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services, LT-PCS

Available Louisiana state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 2006, the PNA in Louisiana is $38 (SSA, 2011; LDH, 2025c).

Elderly and Disabled Adult

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2011-2025

Policy change in 2011
Effective October 1, 2011, Louisiana phased out the Elderly and Disabled Adult program and implemented the Community Choices program, offering a new and expanded home and community-based services (HCBS) benefits package (DHH, 2012). Services such as home-delivered meals, caregiver respite, and skilled therapies were added, and a number of services were reorganized—personal supervision and personal care services were combined into one personal assistant services benefit, and personal emergency response systems were offered under an expanded assistive devices and medical supplies benefit.

Other policy changes during this period:

- (2011) Louisiana home equity limits for Medicaid eligibility begin increasing annually with inflation (LDH, 2025a).
- (2014) Effective July 20, the state's managed care plan called Bayou Health was expanded to allow Community Choices program beneficiaries to opt in, allowing Medicaid beneficiaries to maintain their coverage plans while accessing Community Choices HCBS services (CMS, 2014).
- (2015) Effective July 1, the Long-Term Personal Care Services (LT-PCS) recertification period was extended from annual reevaluations to every 18 months (CMS, 2015).
- (2016) Louisiana adopted Medicaid expansion following the passage of the Affordable Care Act (ACA), creating a new eligibility track covering adults age 19-64 with incomes up to 138% of the federal poverty level, referred to here as eligibility track 2c (ACA expansion adults) (LDH, 2017).
- (2016) The Louisiana Department of Health and Hospitals (DHH) changed its name to the Louisiana Department of Health (LDH) (LSL, 2016). This policy chapter will refer to the LDH throughout when referencing the state agency responsible for administering Medicaid.
- (2016) Louisiana terminated the Louisiana Personal Options Program (La POP), which had allowed beneficiaries to hire and manage the caregiver of their choice when receiving personal care services (CMS, 2017).

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Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility, Community Choices, and LT-PCS program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

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Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Louisiana Medicaid spending on beneficiaries in fiscal year 2011 was 76.24%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Louisiana Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Louisiana.

Eligibility for Medicaid in Louisiana for people needing LTC services is primarily attained by satisfying at least 1 of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount (CMS, 2004a).[1] In 2011, the monthly federal benefit amount was $674 for an individual and $1,011 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (CMS, 2004b). This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[12]
    - Home equity limit: The equity interest in the individual's home may not exceed $506,000, or else they will be ineligible for LTC services. This figure increases annually with inflation. See Table 4 for historical home equity limits.[8]
  - Citizenship/immigration requirements: The applicant must be a Louisiana resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration

and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024) for additional information.
    - ◇ Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
    - ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (CMS, 2004a). In 2011 this was $2,022 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Community Choices program and has a spouse residing in the community.[13] See Table 3 for historical monthly spousal disregards.
    - ◇ Asset requirements: Resources may not exceed $2,000 for an individual (CMS, 2004b). Income for this track is evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is institutionalized or enrolled in the Community Choices program and has a spouse residing in the community.[14] See Table 3 for historical monthly spousal disregards.
        - Asset transfer & Home equity limit: Same as eligibility track 1a.
    - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - ◇ Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a home or community-based LTC program (e.g., Community Choices program).
- 2c. Affordable Care Act (ACA) expansion adults—From 2016
    - ◇ Income requirements: Monthly income may not exceed 138% of the federal poverty level (FPL). In 2016 this was $1,367 for an individual and $1,843 for a household of 2. See Table 2 for historical income limits.
    - ◇ Asset requirements: There is no asset test for this population.
    - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - ◇ Other requirements
        - The applicant must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
    - ◇ Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to be equal to or less than the Medically Needy Income Eligibility Standard (MNIES). Louisiana's MNIES varies by region, with parishes grouped into urban and rural areas. In 2011, the MNIES for rural regions is $92 per month for an individual and $167 per month for a couple. The MNIES for the 4 urban parishes (East Baton Rouge, Jefferson, Orleans, and St. Bernard Parishes) is $100 per month for an individual and $192 per month for a couple (CMS, 2004a; LDH, 2020). These standards have remained the same since 1992. Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled Adult program and has a spouse residing in the community.[5]
    - ◇ Asset requirements: Same asset requirements as eligibility track 1a (CMS, 2004b).
    - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - ◇ Other requirements
        - The applicant must be at least age 65, blind, or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional benefits for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Community Choices
Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 or age 21-64 and disabled. If the program reaches enrollment capacity, the applicant is placed on a waiting list until a spot becomes available (LDH, 2022).

LT-PCS
Applicants must be at least age 65 or age 21-64 and disabled (DHH, 2009).

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Adult Day Health Care (ADHC) program
- Assisted Living program
- Program of All-Inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

Home care benefits vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services
Home health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are limited to 50 visits per year (CMS, 2004c).

Nursing Facility Care
Nursing facility care does not provide home care.

Community Choices
The Community Choices program provides the following home care services (LDH, 2022; LAC 50:XXI §§ 8301-8335, 2025):

- Personal assistant services: Provides supervision and assistance if necessary with ADLs and IADLs
- Skilled nursing services: As described above under Home Health Services, and provided once the 50 service visit limit has been reached.

LT-PCS
LT-PCS provides:

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

LT-PCS visits are limited to 32 hours per week (LAC 50:XV § 12915, 2025).

Community care

Community care benefits vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services, Nursing Facility Care, LT-PCS
These programs do not provide community care.

Community Choices
The Community Choices program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (LAC 50:XXI § 8311, 2025).

Residential care

Residential care benefits vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services, Community Choices, LT-PCS

These programs do not provide residential care.

Nursing Facility Care

Louisiana Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs. Services may include the following (CMS, 2002; LAC 50:II §§10117-10141, 2025):

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by health benefit program. Below we detail other benefits provided by Medicaid state plan benefit programs (Home Health Services, Nursing Facility Care, LT-PCS), followed by Louisiana's largest home and community-based services (HCBS) program.

Louisiana Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Community Choices

The Community Choices program provides the following services in addition to those offered under the state plan, unless otherwise noted (LAC 50:XXI §§ 8301-8335, 2025):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care, referred to in Louisiana as "Support coordination"
- Home-delivered meals: Meal preparation and delivery to the beneficiary of up to two nutritionally balanced meals per day
- Transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., financial support for moving expenses)
- Transition intensive support coordination: Case management services for nursing facility residents seeking to transition back to a home and community-based setting
- Environmental accessibility adaptation: Necessary physical adaptations made to the home to ensure the health, safety, welfare, and independent functioning of the recipient
- Assistive devices and medical supplies (assistive technology): Specialized medical equipment and supplies necessary to address the beneficiary's functional limitations, including the installation and monitoring of electronic devices allowing the beneficiary to secure help in an emergency (Personal emergency response system—PERS)
- Caregiver temporary support: Institutional and home health services furnished on a short-term basis to relieve informal caregivers who require absence or relief from caregiving duties, in order to maintain the informal support system (often referred to as "Respite")
- Monitored in-home caregiving: Professional oversight and support for services provided by a live-in caregiver (e.g., a spouse or a legal guardian)
- Skilled maintenance therapy: Includes physical, occupational, and speech therapies focused on the functional need or the reduction of decline in the beneficiary's ability to carry out activities of daily living
- Housing transition or crisis intervention: Services enabling beneficiaries who are transitioning to a permanent supportive housing unit to secure their own housing or provide assistance when the beneficiary's housing is placed at risk
- Housing stabilization: Enable beneficiaries, once housed, to successfully maintain residency and tenancy
- Financial management: Assistance for beneficiaries who are able to choose and manage the staff who provide their program services

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Louisiana Department of Health (LDH). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by registered nurses, and home health aide services are provided by home health aides employed by state-certified home health agencies. Home health aide services are provided under the direction of a registered nurse (LR, 2002b, 1094; LAC 50:XIII §§ 101-105, 2025).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (42 CFR 483.30).

Community Choices

Community Choices program services are provided by authorized staff of state-approved personal care attendant provider agencies, and are coordinated by trained staff of support coordination agencies (LAC 50:XII §§ 8301-8335, 9303, 2025).

LT-PCS

Personal care services are provided by licensed personal care workers employed by state-certified personal care attendant agencies (LR, 2003b, p. 913, LAC 50:XV § 12909, 2025).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 4 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury (LAC 50:XIII § 301, 2025).

Nursing Facility Care

Beneficiaries must meet a nursing facility level of care (NFLOC) by having a physician certify the medical necessity of their nursing home placement. A beneficiary qualifies as requiring an NFLOC by satisfying 1 of 7 eligibility pathways on the LOCET (LAC 50:II § 503, 2025).

Community Choices

Beneficiaries must meet an NFLOC by satisfying 1 of 7 eligibility pathways on the LOCET (LAC 50:XXI § 8101, 2025).

LT-PCS

Personal care services must be medically necessary and prior authorized by the LDH. Personal care services are medically necessary if the beneficiary meets an NFLOC and if they are able to direct the services of a personal care worker either independently or through a designated representative (LR, 2006a, 2082). A beneficiary qualifies as requiring an NFLOC by satisfying 1 of 7 eligibility pathways on the Level of Care Eligibility Tool (LOCET) (LAC 50:XV § 12901, 2025).

Duration of benefit

Reassessments of eligibility vary by health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the 4 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (LR, 2002b, 1093, LAC 50:XIII § 103, 2025).

Nursing Facility Care

Nursing facility level of care (NFLOC) must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities. After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20; 42 CFR 483.128).

Community Choices, LT-PCS

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (LDHH, 2009; LAC 50:XII § 8107, 2025).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 4 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Community Choices, LT-PCS

The individual must be at least age 65, or 21-64 and disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury (LAC 50:XIII § 103, 2025).

Nursing Facility Care, Community Choices, LT-PCS

Beneficiaries must meet a nursing facility level of care (NFLOC) by satisfying 1 of 7 eligibility pathways as assessed on the Level of Care Eligibility Tool (LOCET). The 7 pathways are (LR 2006c, p. 2083; LR 2011, p. 342):

- Activities of Daily Living (ADLs) Pathway: The beneficiary must require at least extensive assistance in eating, or at least limited assistance in either toilet use, transferring, or bed mobility
- Cognitive Performance Pathway: Identifies beneficiaries with cognitive difficulties in short-term memory, daily decision making, and making oneself understood
- Physician Involvement Pathway: Within the last 14 days, the beneficiary must have had at least 1 doctor visit with 4 order changes or more, or at least 2 days of doctor visits with 2 order changes or more
- Treatments and Conditions Pathway: The beneficiary must have at least 1 of 9 medical treatments or conditions over the past 7-14 days
- Skilled Rehabilitation Therapies Pathway: The beneficiary must have received within the prior week, or be scheduled to receive within the following week, at least 45 minutes of active physical, occupational, and/or speech therapy
- Behavior Pathway: The beneficiary must have exhibited at least 1 listed behavior on at least 4-6 out of the prior 7 days —these include wandering, verbally abusive behavior, physically abusive behavior, socially inappropriate or disruptive behavior, and resisting care

- Service Dependency Pathway: This pathway is for beneficiaries who currently receive LT-PCS, nursing facility, or Elderly and Disabled Adult program services that were initially approved prior to the December 1, 2006 implementation of the LOCET, and for whom ongoing services are required to maintain their current functional status

For more information on the eligibility thresholds required to satisfy each pathway see Box 3 for pathways 1 through 4, and Box 4 for pathways 5 through 7.

Evaluation of dependence

Evaluations of dependence vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services in accordance with a plan of care that establishes medical need. Services must be authorized in advance, and the beneficiary must be seen by a physician at least every 60 days to recertify their continuing need for home health services (LR, 2002b, p. 1093).

Nursing Facility Care

Two forms are submitted to the Louisiana Department of Health (LDH) within 20 days of nursing facility admission: a LOCET assessment certifying that the individual meets an NFLOC, and a federally required Preadmission Screening and Resident Review (PASRR) certifying that the individual does not require specialized care for a mental illness or intellectual disability. After the initial admission process, the beneficiary's functional limitations and care needs are assessed periodically using the federally mandated Minimum Data Set (MDS) (LR, 2006d, p. 2085; LAC 50:II § 503, 2025). For more information on LOCET eligibility thresholds see Box 3 for pathways 1 through 4, and Box 4 for pathways 5 through 7. See Box 1 for more information on the PASRR, and Box 2 for more information on the MDS.

Community Choices

Individuals must first contact the LDH to be placed on a Request for Services Registry, a statewide waitlist for program slots maintained by the department. Individuals are screened using the LOCET to determine whether they meet an NFLOC and satisfy other age or disability-related criteria for program entry before their names are added to the registry waitlist. For more information on LOCET eligibility thresholds see Box 3 for pathways 1 through 4, Box 4 for pathways 5 through 7, and (DHH, 2010) for a copy of the LOCET assessment tool. Once a slot becomes available, a comprehensive assessment of the beneficiary's functional limitations and care needs is conducted using the Minimum Data Set for Home Care (MDS-HC) in order to build the beneficiary's plan of care (LR 30:1699; LAC 50:XXI § 8103, 2025). The MDS-HC collects information on a range of functional and cognitive limitations including ADLs, cognitive abilities, behavioral issues, communication patterns, mood, vision, and social supports (DHH, 2010).

LT-PCS

NFLOC is certified using the Level of Care Eligibility Tool (LOCET) to determine program entry. The LOCET collects information on ADL limitations, cognitive performance, behavioral issues, physician's orders, medical treatments, and skilled rehabilitative therapies in order to determine whether the individual qualifies through 1 of 7 eligibility pathways. For more information on LOCET eligibility thresholds see Box 3 for pathways 1 through 4, Box 4 for pathways 5 through 7, and (DHH, 2010) for a copy of the LOCET assessment tool. Once NFLOC criteria have been met the beneficiary is assessed using the MDS-HC to identify long-term care needs and build their plan of care (DHH, 2009, 30.5; LR, 2013, p. 2506).

Evaluators

Evaluators vary by health benefit program. The details of the 4 largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop a written plan of care, and periodically review the plan of care (LR, 2002b, p. 1093, LAC 50:XIII § 103, 2025).

Nursing Facility Care

A licensed physician must certify the beneficiary's need for nursing facility care, and periodic assessments using the Minimum Data Set (MDS) are conducted or coordinated by a registered nurse (LR, 2006d, p. 2085, LAC 50:II § 503, 2025).

Community Choices

A licensed physician must certify that the beneficiary meets an NFLOC, and must order services by developing a plan of care. These documents are submitted to the LDH for final approval to determine eligibility for program services (LR 1998, p. 42, LAC 50:XXI § 8103, 2025).

LT-PCS

Personal care services must be authorized by the provider agency in a plan of care that is submitted to the Department of Health (LDH) for final approval (LR, 2003b, p. 911, LAC 50:XV § 12901, 2025).

Benefit limitations

Can you mix LTC benefits?

All Louisiana Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 4 largest programs.

Medicaid

As required by federal law, Louisiana enforces Estate Recovery. The acceptance of Medicaid in Louisiana creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility care, or for the receipt of HCBS program services after the recipient reaches 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services, LT-PCS

Available Louisiana state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 2011, the PNA in Louisiana is $38 (SSA, 2011; LDH, 2025c).

Community Choices

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Louisiana Federal Medical Assistance Percentage (FMAP) for Medicaid (1992-2025)

Fiscal Year	FMAP
1992	75.44%
1993	73.71
1994	73.49
1995	72.65
1996	71.89
1997	71.36
1998	70.03
1999	70.37
2000	70.32
2001	70.53
2002	70.30
2003	72.76
2004	73.84
2005	71.04
2006	69.79
2007	69.69
2008	72.47
2009	80.20
2010	81.48
2011	76.24
2012	69.78
2013	65.51
2014	62.11
2015	62.05
2016	62.21
2017	62.28
2018	63.69
2019	65.00
2020	71.51
2021	73.62
2022	74.22
2023[1]	72.26
2024	68.05
2025	68.06

Source: US DHHS (2025)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201).

[1]The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Louisiana Medicaid Income Limits (1992-2025)

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	138% FPL (Individual)	138% FPL (Couple)
1992	$422	$633	$1,266	$1,899		
1993	434	652	1,302	1,956		
1994	446	669	1,338	2,007		
1995	458	687	1,374	2,061		
1996	470	705	1,410	2,115		
1997	484	726	1,452	2,178		
1998	494	741	1,482	2,223		
1999	500	751	1,500	2,253		
2000	513	769	1,539	2,307		
2001	531	796	1,593	2,388		
2002	545	817	1,635	2,451		
2003	552	829	1,656	2,487		
2004	564	846	1,692	2,538		
2005	579	869	1,737	2,607		
2006	603	904	1,809	2,712		
2007	623	934	1,869	2,802		
2008	637	956	1,911	2,868		
2009	674	1,011	2,022	3,033		
2010	674	1,011	2,022	3,033		
2011	674	1,011	2,022	3,033		
2012	698	1,048	2,094	3,144		
2013	710	1,066	2,130	3,198		
2014	721	1,082	2,163	3,246		
2015	733	1,100	2,199	3,300		
2016	733	1,100	2,199	3,300	$1,367	$1,843
2017	735	1,103	2,205	3,309	1,387	1,868
2018	750	1,125	2,250	3,375	1,397	1,893
2019	771	1,157	2,313	3,471	1,437	1,945
2020	783	1,175	2,349	3,525	1,468	1,983
2021	794	1,191	2,382	3,573	1,482	2,004
2022	841	1,261	2,523	3,783	1,564	2,106
2023	914	1,371	2,742	4,113	1,677	2,268
2024	943	1,415	2,829	4,245	1,732	2,351
2025	967	1,450	2,901	4,350	1,800	2,432

Source: SSA (2025a)

Notes: Income limits for individuals and couples are monthly. Income limits at 138% of the federal poverty level (FPL) begin in 2016, corresponding to Louisiana's implementation of this track.

Table 3: Louisiana Spousal Impoverishment Standards (1992-2025)

Year	Maximum MMNA	Maximum CSRA
1992	$1,718.00	$68,700
1993	1,769.00	70,740
1994	1,817.00	72,660
1995	1,870.50	74,820
1996	1,918.50	76,740
1997	1,975.50	79,020
1998	2,019.00	80,760
1999	2,049.00	81,960
2000	2,103.00	84,120
2001	2,175.00	87,000
2002	2,232.00	89,280
2003	2,267.00	90,660
2004	2,319.00	92,760
2005	2,377.50	95,100
2006	2,488.50	99,540
2007	2,541.00	101,640
2008	2,610.00	104,400
2009	2,739.00	109,560
2010	2,739.00	109,560
2011	2,739.00	109,560
2012	2,841.00	113,640
2013	2,898.00	115,920
2014	2,931.00	117,240
2015	2,980.50	119,220
2016	2,980.50	119,220
2017	3,022.50	120,900
2018	3,090.00	123,600
2019	3,160.50	126,420
2020	3,216.00	128,640
2021	3,259.50	130,380
2022	3,435.00	137,400
2023	3,715.50	148,620
2024	3,853.50	154,140
2025	3,948.50	157,920

Source: LDH (2025b)

Notes: Federal law requires states to set the monthly maintenance needs allowance (MMNA) standard at no more than $1,500, increasing annually with inflation starting on January 1, 1990. For Community Spouse Resource Allowances (CSRAs), the maximum was set at $60,000 as of September 30, 1989, increasing each year with inflation. MMNAs and CSRAs are calculated using the Consumer Price Index for urban consumers (CPI-U).

Box 1: Preadmission Screening and Resident Review (PASARR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASARR). The purpose of the PASARR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level I screening), and a final determination. All applicants of Medicaid-certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASARR evaluation.

Source: 42 CFR 483.100-138

Box 2: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: CMS (2025)

Table 4: Louisiana Home Equity Limits (2007-2025)

Year	Home equity limit
2007	$500,000
2008	500,000
2009	500,000
2010	500,000
2011	506,000
2012	525,000
2013	536,000
2014	543,000
2015	552,000
2016	552,000
2017	560,000
2018	572,000
2019	585,000
2020	595,000
2021	603,000
2022	636,000
2023	688,000
2024	713,000
2025	730,000

Source: LDH (2025a)

Notes: The limit was $500,000 from November 2007 to December 2010, after which the equity limit began increasing annually with inflation.

Box 3: Louisiana Nursing Facility Level of Care Eligibility Pathways (2006-2025) Part 1

Beneficiaries meet a nursing facility level of care (NFLOC) by satisfying any 1 of 7 eligibility pathways. See below for pathways 1 through 4, and see Box 4 for pathways 5 through 7 (Skilled rehabilitation therapies, Behaviors, and Service dependency).

1. Activities of Daily Living (ADLs) Pathway: The level of care eligibility tool (LOCET) collects information on 8 ADLs to assess overall functional capacity and assistance received, with performance in the following 4 ADLs used to trigger an NFLOC through this eligibility pathway. The beneficiary must require the level of assistance indicated in any one of the following:
    - Toileting: The beneficiary must require at least limited assistance with tasks such as getting on and off the toilet, wiping, and arranging clothing.
    - Transferring: The beneficiary must require at least limited assistance with moving from one surface to another (excluding getting on and off the toilet and getting in and out of the tub or shower).
    - Bed mobility: The beneficiary must require at least limited assistance with moving around while in bed.
    - Eating: The beneficiary must require at least extensive assistance with consuming food (excluding meal preparation).
    - The following scale is used to determine the level of assistance required:
        - ◇ Independent: No help or oversight, or help or oversight provided only 1 or 2 times during last 7 days
        - ◇ Supervision: Oversight, encouragement, or cueing provided 3 or more times during last 7 days, or supervision 3 or more times plus physical assistance provided only 1 or 2 times during last 7 days
        - ◇ Limited assistance: Received physical help in guided maneuvering of limbs or other assistance 3 or more times, or more help provided only 1 or 2 times during last 7 days
        - ◇ Extensive assistance: Full performance by another was required 3 or more times over the last 7 days
        - ◇ Total dependence: Full performance by another was required during all of the last 7 days
        - ◇ Activity did not occur: Activity did not occur during entire 7 days prior, regardless of ability
2. Cognitive Performance Pathway: The individual is assessed based on their short-term memory, daily decision making capacity, and ability to make themselves understood. The following scales are used to determine the level of impairment for each cognitive performance indicator:
    - Short-term Memory: Does the applicant appear to recall recent events, for instance, when the applicant ate his/her last meal and what he/she ate?
    - Cognitive Skills for Daily Decision-making: How does the applicant make decisions about the tasks of daily life, such as planning how to spend their day, choosing what to wear, reliably using canes/walkers or other assistive equipment if needed?
    - Making Self Understood: How clearly is the applicant able to express or communicate his/her needs/requests?
    - In order to trigger an NFLOC through this pathway, the individual must satisfy 1 of the following statements:
        - ◇ Be severely impaired in daily decision making, never or rarely makes decisions
        - ◇ Has short-term memory problem and is at least moderately impaired in daily decision making
        - ◇ Has short-term memory problem and is sometimes or rarely understood
        - ◇ Moderately impaired in daily decision making and is often (prompting usually required), sometimes (limited ability to make concrete requests), or rarely understood
3. Physician Involvement Pathway: This pathway identifies beneficiaries with unstable medical conditions that may affect their ability to care for themselves. In order to trigger an NFLOC through this pathway, the beneficiary must satisfy 1 of the following:
    - One day of doctor visits and at least 4 new order changes all occurring during the past 14 days
    - At least 2 days of doctor visits AND at least 2 new order changes all occurring during the past 14 days
4. Treatments and Conditions Pathway: This pathway identifies beneficiaries with unstable medical conditions that may affect their ability to care for themselves. In order to trigger an NFLOC through this pathway, the beneficiary must have any 1 of the following:
    - Stage 3-4 pressure sores in the last 14 days
    - Intravenous feedings in the last 7 days
    - Intravenous medications in the last 14 days
    - Daily tracheostomy care and ventilator/respiratory suctioning in the last 14 days
    - Pneumonia in the last 14 days and the individual's associated IADL or ADL needs or restorative nursing care needs
    - Daily respiratory therapy provided by a qualified professional in the last 14 days
    - Daily insulin injections with 2 or more order changes in the last 14 days
    - Peritoneal or hemodialysis in the last 14 days

Source: LR 2011, p. 342, DHH (2010)

Box 4: Louisiana Nursing Facility Level of Care Eligibility Pathways (2006-2025) Part 2

Beneficiaries meet a nursing facility level of care (NFLOC) by satisfying any 1 of 7 eligibility pathways. See Box 3 for pathways 1 through 4 (ADLs, Cognitive performance, Physician involvement, and Treatments and conditions) and below for pathways 5 through 7.

5. Skilled Rehabilitation Therapies Pathway: In order to qualify for an NFLOC through this pathway, the beneficiary must have received at least 45 minutes of physical, occupational, and/or speech therapy during the last seven days or have at least 45 minutes scheduled for the next 7 days.
6. Behavior Pathway: This pathway identifies individuals with behavioral challenges that impact their ability to function in the community. To qualify for an NFLOC through this pathway, the beneficiary must have exhibited any of the following behaviors during 4 to 6 of the prior 7 days:
    - Wandering
    - Verbally abusive
    - Physically abusive
    - Socially inappropriate or disruptive
    - Resisted care
7. Service Dependency Pathway: This pathway is for individuals who were approved for nursing facility, Elderly and Disabled Adult program, and LT-PCS program services prior to December 1, 2006, and who continue to require ongoing services.

Source: LR 2011, p. 342, DHH (2010)

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): ADHC is a community-based long term care benefit that provides nursing care, personal care, social, nutritional, and therapeutic services, typically furnished in a community center for four or more hours per day at least once per week.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably is the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Bayou Health: Louisiana's managed care health plan for Medicaid recipients, providing health plans through five private companies with different networks of providers and hospitals than traditional Medicaid. Long-term care was carved out of Bayou Health's managed care plans until 2014 when beneficiaries of home and community-based service programs such as Community Choices were given the option to enroll in one of the state's managed care plans if desired. In 2016, Bayou Health was renamed Healthy Louisiana.

Community Choices: Louisiana program providing home and community-based services to a limited number of Medicaid recipients under federal 1915(c) waiver authority. In 2011 the Community Choices program replaced the Elderly and Disabled Adult program, providing an expanded benefit package to the same target population.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Companion Services: Companion services provide care, supervision, and socialization during the day or night to functionally impaired beneficiaries of the Elderly and Disabled Adult program. This benefit emphasizes supervision over personal care, which is provided primarily through the long-term personal care services (LT-PCS) state plan benefit. Companion services were provided between 2006-2011.

Consumer-directed personal care services: Personal care services hired by an aide who is hired and managed by the recipient.

Council on Aging: Local parish-based agency responsible for helping to administer and provide non-Medicaid support services to the elderly. Until 2002, local Councils on Aging managed waiting lists and program entry for the Elderly and Disabled Adult program, after which these responsibilities were consolidated under the Louisiana Department of Health and Hospitals (DHH).

Elderly and Disabled Adult: Louisiana program providing home and community-based services (HCBS) to a limited number of Medicaid recipients age 65 and over or 22-64 with a disability under federal 1915(c) waiver authority. From 1993-1997 this program was called the Home Care for the Elderly program and offered HCBS to individuals age 65 and over only.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). In the relatively rare instance where this track applies to HCBS recipients only, eligibility is granted based on whether an individual would be eligible if institutionalized and institutional rules still apply. It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual typically must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Services provided in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Homebound: An individual is considered homebound if they have a condition due to illness or injury that makes leaving the home medically inadvisable.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Level of Care Eligibility Tool (LOCET): Louisiana screening and assessment instrument that is used to determine whether a Medicaid beneficiary meets the nursing facility level of care (NFLOC) requirement to be eligible for certain long-term care services (nursing facility care, long-term personal care services, and Elderly and Disabled Adult/Community Choices program services).

Long-Term Personal Care Services (LT-PCS): Louisiana's Medicaid state plan personal care services benefit program, offering assistance with activities of daily living to eligible beneficiaries.

Louisiana Department of Health (LDH): From 2016, Louisiana's single state agency responsible for administering the state Medicaid program.

Louisiana Department of Health and Hospitals (DHH): Louisiana's single state agency responsible for administering the state Medicaid program, until 2016 when it was renamed the Louisiana Department of Health (LDH).

Louisiana Personal Options Program (La POP): Louisiana program allowing beneficiaries of Medicaid state plan personal care services (LT-PCS) to self-direct their care by hiring and managing the care provider of their choice.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid state plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

Medically Needy Income Eligibility Standard (MNIES): The standard that a Medicaid applicant must spend down to meet if they are seeking Medicaid eligibility through eligibility track 3a (medically needy aged, blind, and disabled). In other states this standard is often referred to as the Medically Needy Income Limit (MNIL).

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Minimum Data Set for Home Care (MDS-HC): A globally standardized assessment system for home care also known as the InterRAI-HC that is compatible with national MDS standards for nursing facilities, allowing for a more integrated assessment system across long-term care programs.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Notice of Admission, Status Change, or Discharge Form 148: Louisiana form used to verify whether a nursing facility resident is being admitted as a Medicaid or Medicare beneficiary, or as a private pay resident.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing Facility Level of Care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Program of All-Inclusive Care for the Elderly (PACE): A federally authorized program that provides comprehensive medical and social services to elderly individuals requiring a nursing facility level of care. PACE programs are typically provided under Medicare, however states can elect to provide PACE services to Medicaid beneficiaries as an optional benefit. Enrollment in PACE programs is typically capped at a relatively low number of participants.

Permanently Residing Under Color of Law (PRUCOL): An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility. In Louisiana the state plan benefit is referred to as the Long Term Personal Care Services (LT-PCS) program, while personal care services are referred to as personal care attendant services when provided by the Elderly and Disabled Adult or Community Choices programs.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

Qualified Income Trust (QIT): A Qualified Income Trust (QIT), or Miller Trust, is an irrevocable trust that allows individuals with excess income to qualify for Medicaid benefits under eligibility track 2a (Institutional rules). Each month, the beneficiary's excess income is deposited in the QIT, and a designated trustee can use these funds for limited purposes that include the beneficiary's monthly personal needs allowance, residential care facility costs, community spouse allocations, and any other care-related expenses. When the beneficiary passes away, any remaining funds in the account are claimed by the State.

Request for Level of Care Determination Form 90-L: Form used to certify that a Medicaid beneficiary meets the nursing facility level of care (NFLOC) required for certain long-term care service benefits.

Respite care: Services provided to participants who are unable to care for themselves, furnished on a short-term basis because of the

absence or need of relief for those persons normally providing care for the participant.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Disability Insurance (SSDI) : Federal program providing cash assistance to Americans with disabilities and qualifying work history, as determined by the Social Security Administration.

State Supplemental Payment (SSP): Monthly cash payments offered by states to low-income individuals in addition to Supplemental Security Income (SSI). States offering optional SSPs may do so to account for higher costs of living or as an additional income disregard for individuals in certain living arrangements (e.g., nursing facility). In Louisiana, an $8 state supplement is paid to nursing facility residents, bringing the personal needs allowance up to a total $38.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. SSI recipients in some states receive a State Supplementary Payment (SSP). Louisiana provides an $8 supplementary payment to Medicaid-certified nursing home residents, bringing their total personal needs allowance up to $38.

2. In 1992 the look back period was 30 months prior to the date of application for all assets. In 1993 the look back period was extended to 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period was 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).

3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of a nd permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).

4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2024) for more information on these requirements.

5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the MMNA in Louisiana was $1,718 per month.

6. Spousal considerations for assets: The community spouse is also able to keep 100% of the couple's countable assets up to the maximum federal Community Spouse Resource Allowance (CSRA), which was $68,700 in 1992. Countable assets/property are real and personal property that are counted to determine eligibility.

7. Louisiana terminated its medically needy program on June 30, 1996, and reimplemented it on July 1, 1997. During this lapse, individuals were given the option to spend down their excess income by setting up a Qualifying Income Trust (QIT). Once the medically needy eligibility track was reinstated in 1997 QITs were no longer authorized. See LDH (2023) for more information.

8. In 2006 the Deficit Reduction Act extended the look back period to 60 months for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).

9. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.
10. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2004, the MMNA in Louisiana was $2,319 per month.
11. Spousal considerations for assets: The community spouse is also able to keep 100% of the couple's countable assets up to the maximum federal Community Spouse Resource Allowance (CSRA), which was $92,760 in 2004. Countable assets/property are real and personal property that are counted to determine eligibility.
12. The look back period is 60 months prior to the date of application for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult.
13. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2011, the MMNA in Louisiana was $2,739 per month.
14. Spousal considerations for assets: The community spouse is also able to keep 100% of the couple's countable assets up to the maximum federal Community Spouse Resource Allowance (CSRA), which was $109,560 in 2011. Countable assets/property are real and personal property that are counted to determine eligibility.

Version information

Current Version: 1.0 (April 2025)

Version History

- 1.0 (April 2025): First version.