

Oregon: Bending the LTSS Cost Curve

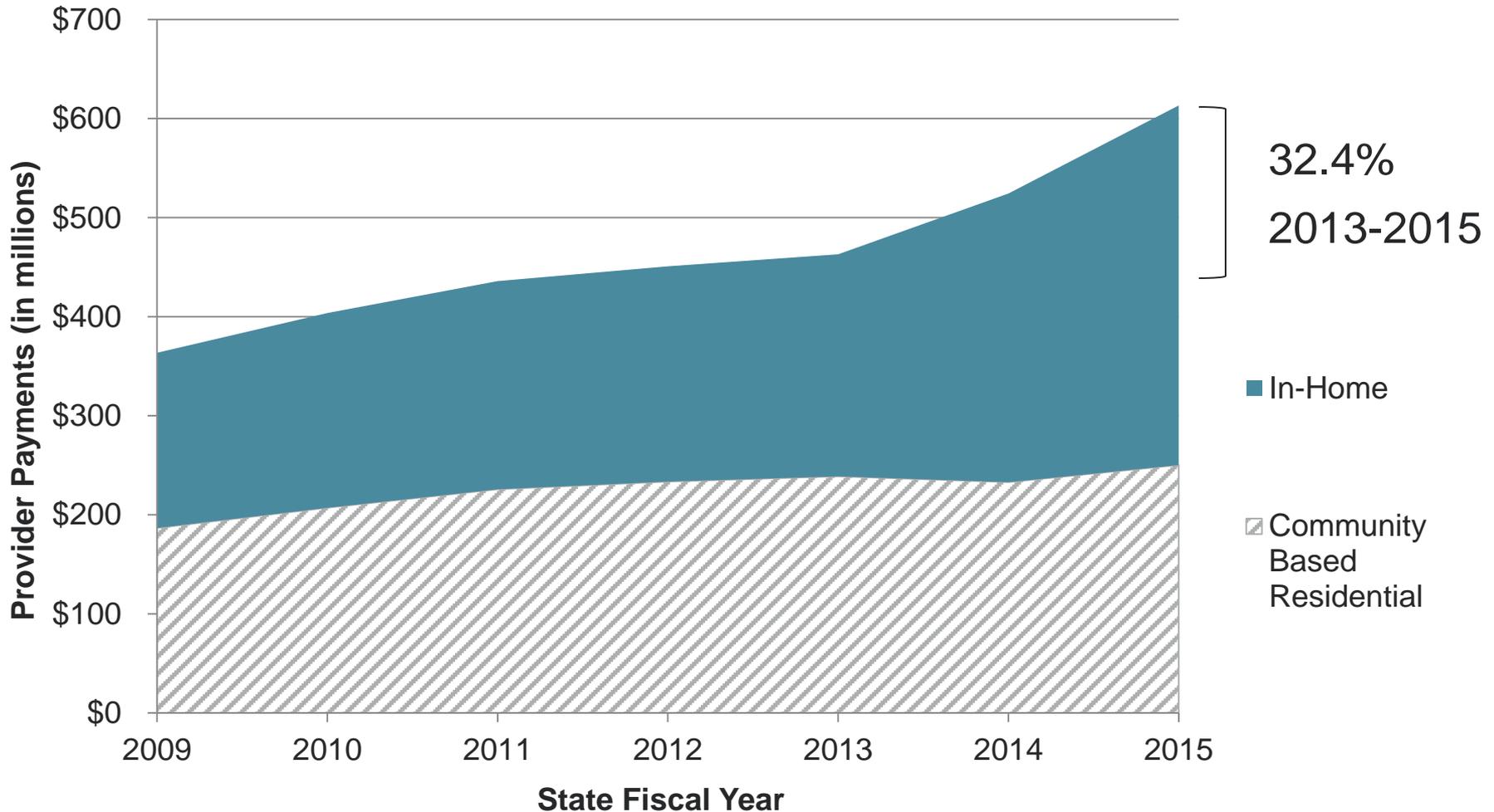
Presentation Overview

- Historical Caseload and Expenditure Analysis
 - APD
 - IDD
- Policy Scenarios
 - Description
 - Fiscal Implications
 - Consumer
 - Description of consumers impacted
 - Including stakeholder feedback

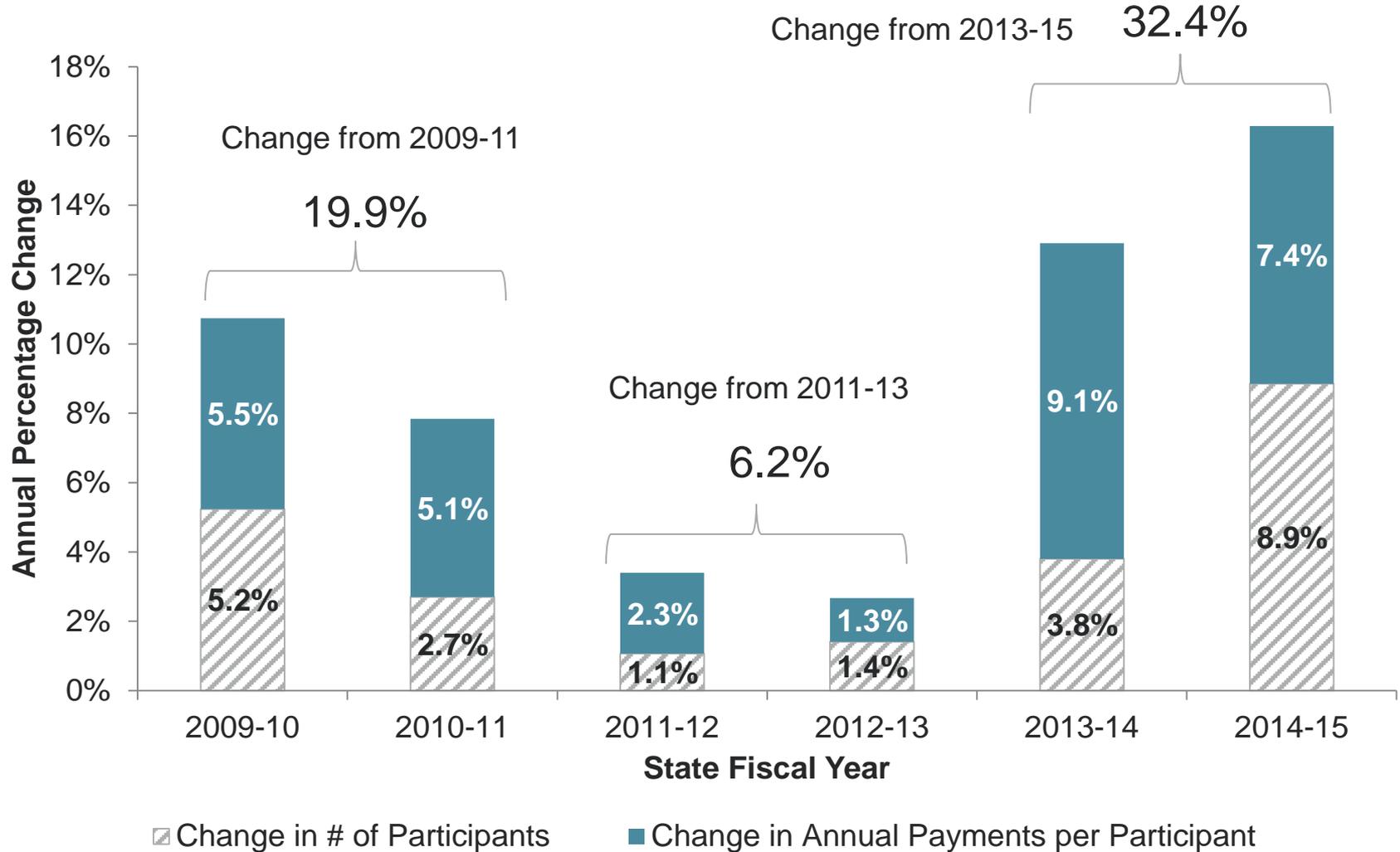
MEDICAID HISTORICAL CASELOAD AND EXPENDITURES

- APD - Aging and People with Disabilities
- IDD - Intellectual and Developmental Disabilities
- HCBS - Home and Community Based Services
 - Includes all IDD services except case management only and children's intensive in-home services
 - Includes all APD services except nursing facility

APD HCBS Spending Increased 70% SFY 2009-15

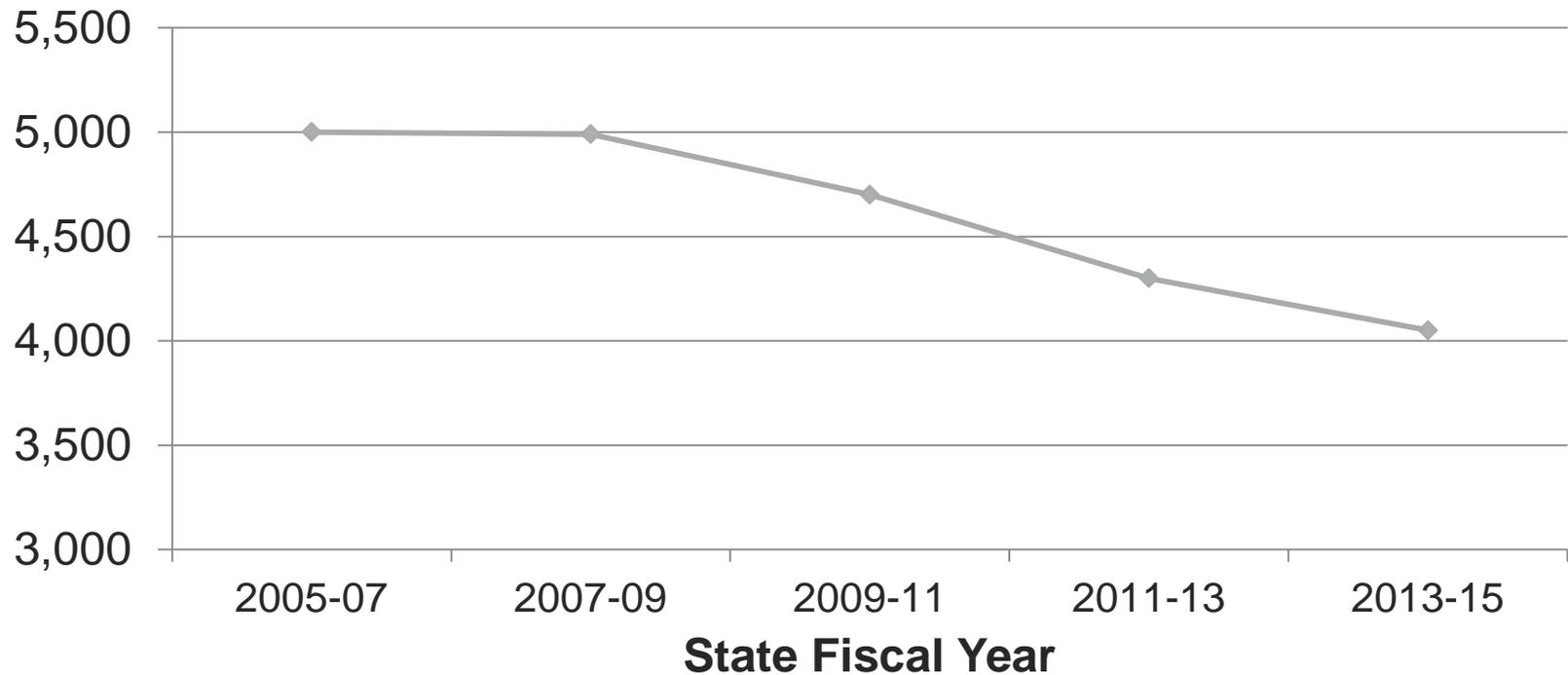


For Biennium Prior to K Plan, APD HCBS Spending Increased 6.2%

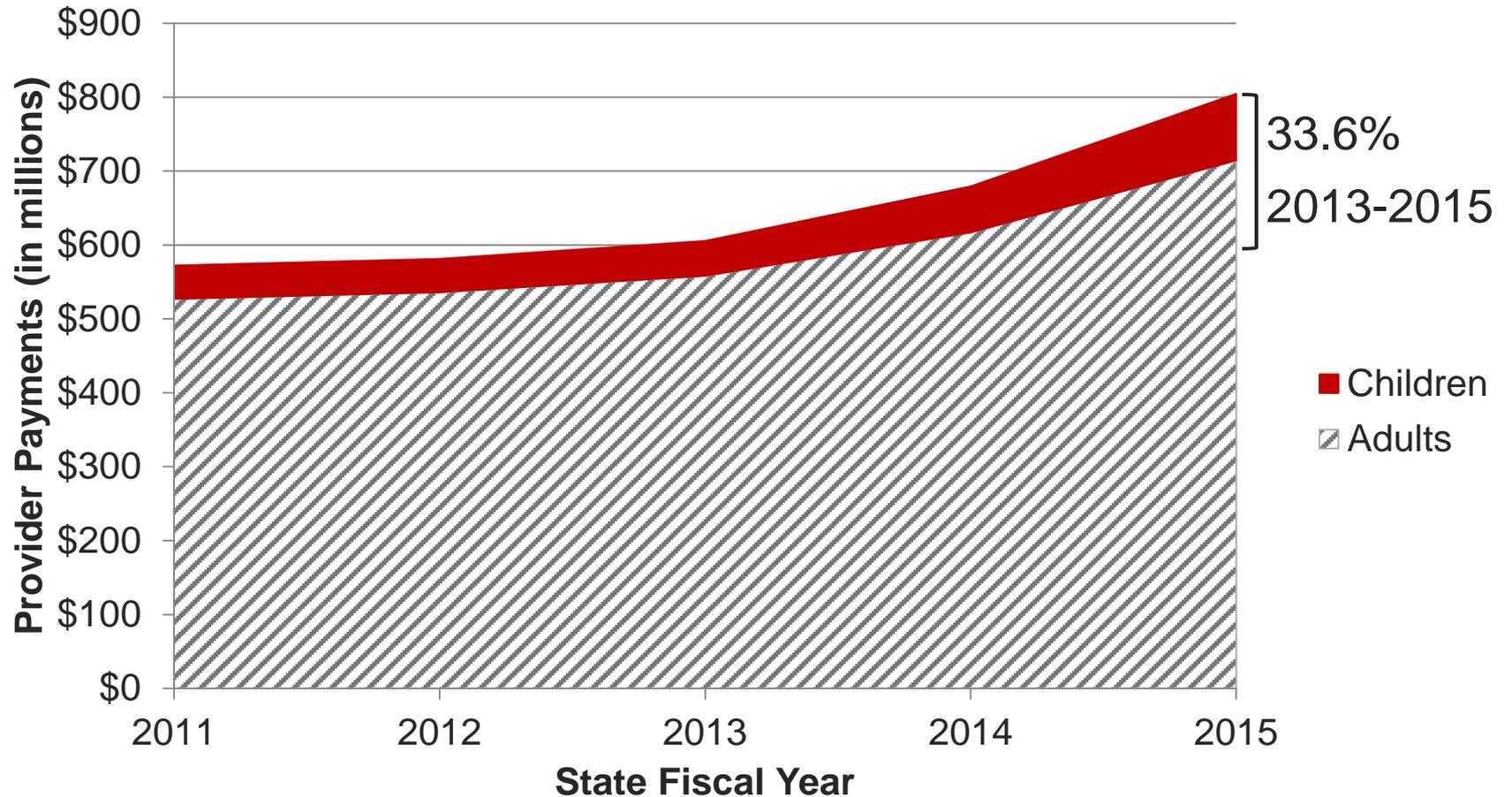


Nursing Facilities Continue to Have a Declining Caseload

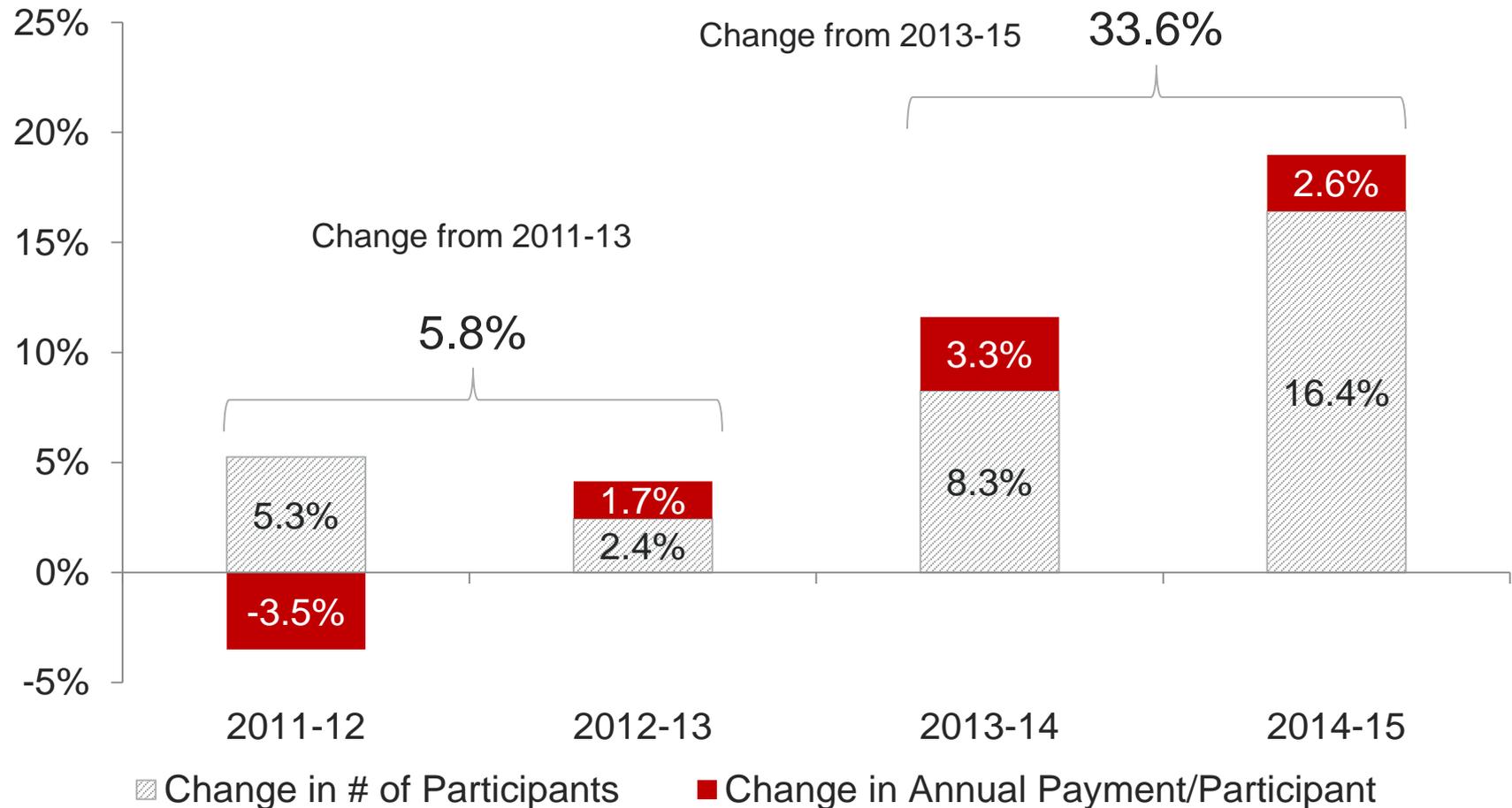
Average Monthly Medicaid Nursing Facility Residents



IDD Spending Increased 41% SFY 2011-15



Caseload and Payments/Participant Increases Driving IDD Growth



Excludes case management only and children's intensive in-home participants.

POLICY SCENARIOS

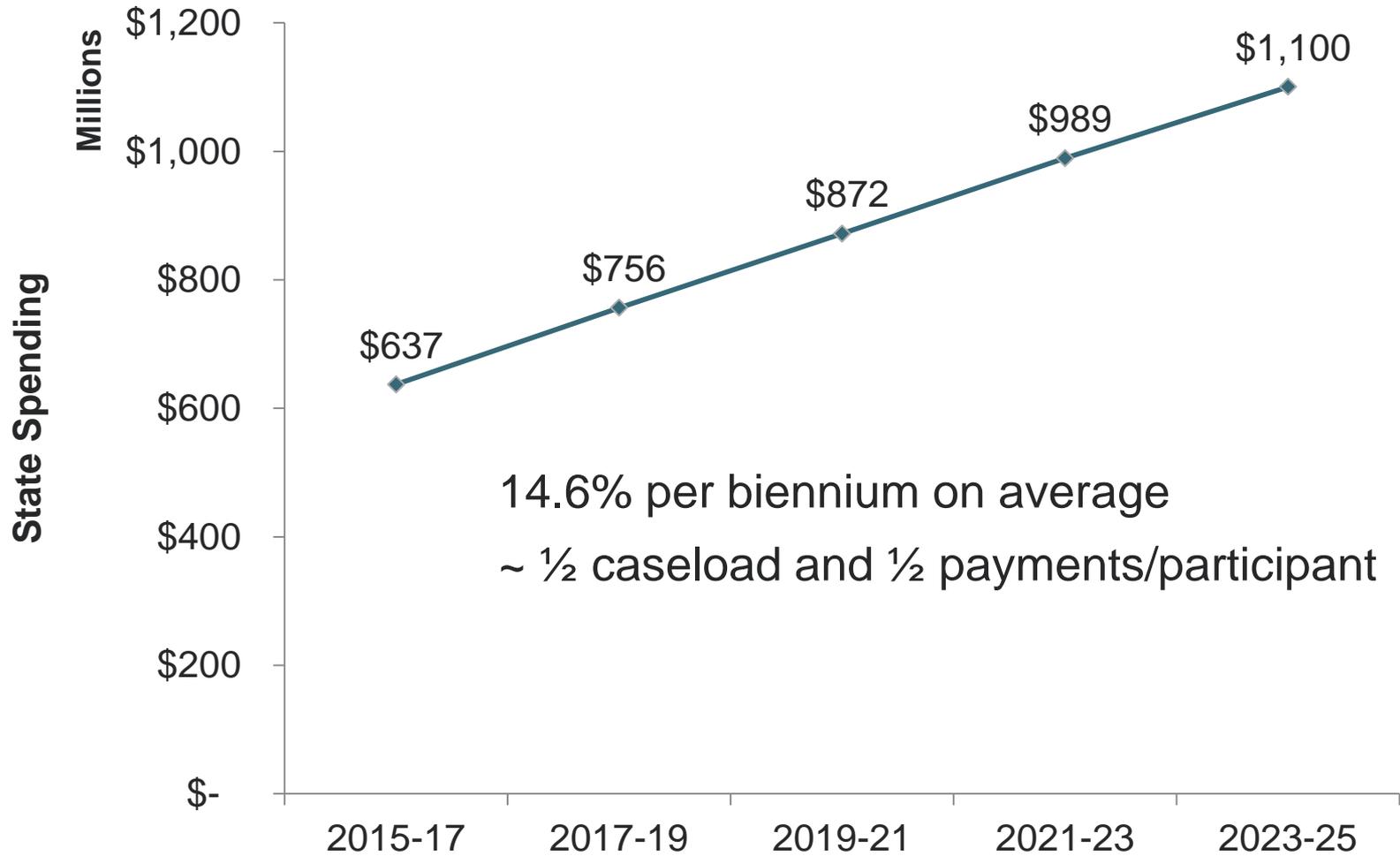
Scenarios Explored

- Reduce the number of, or the rate of increase, in LTSS recipients
- Reduce or redistribute the amount of services authorized
- Change participant cost-share
- Increase integration
- Leverage technology

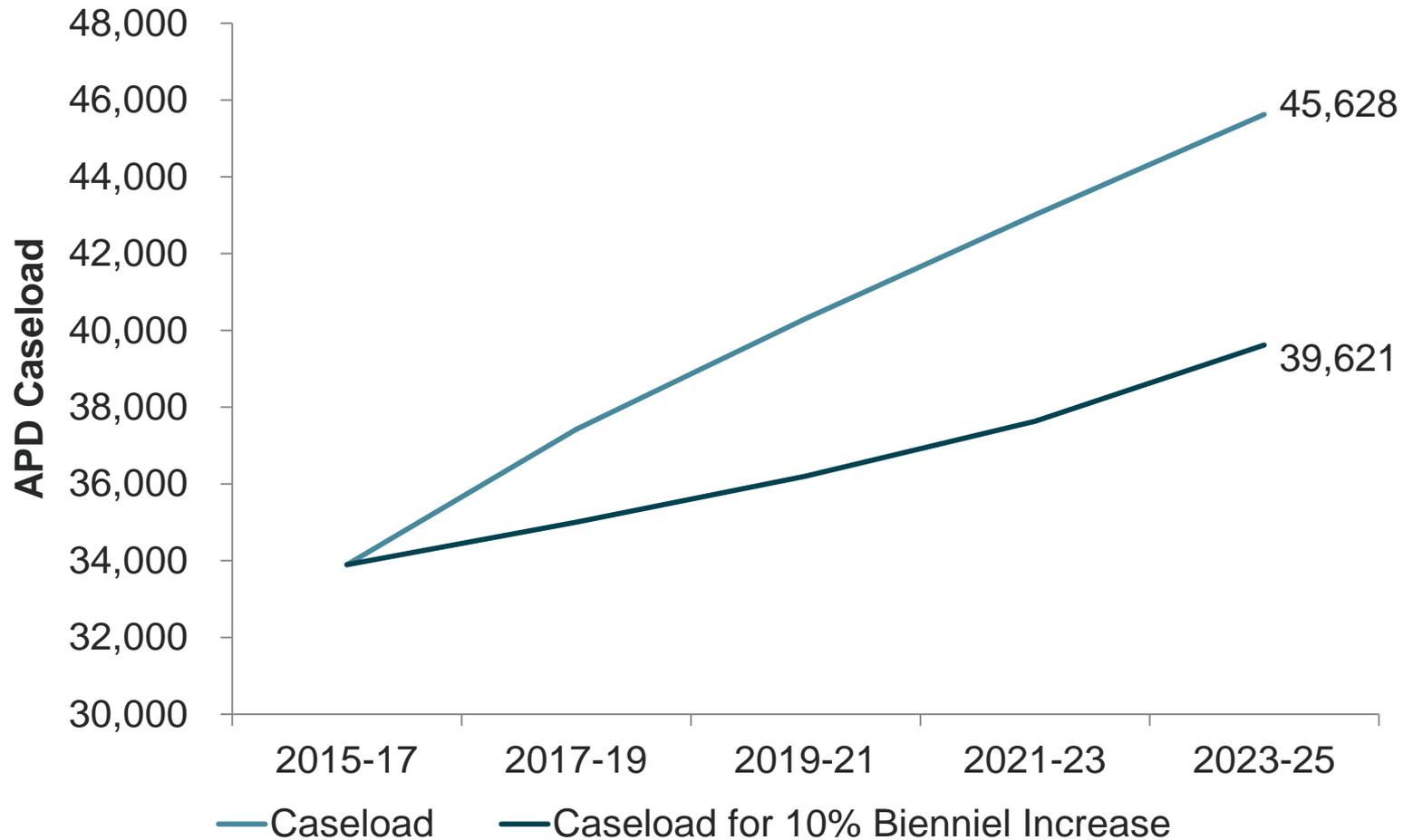
REDUCE THE NUMBER OF LTC RECIPIENTS

1. Changes needed to meet 10% biennial increase
 - APD
 - IDD
2. Changes to Functional Eligibility
 - Increase required Service Priority Levels (SPL) for APD
 - Change IQ and/or Require Additional Areas of Functional Impairment for IDD

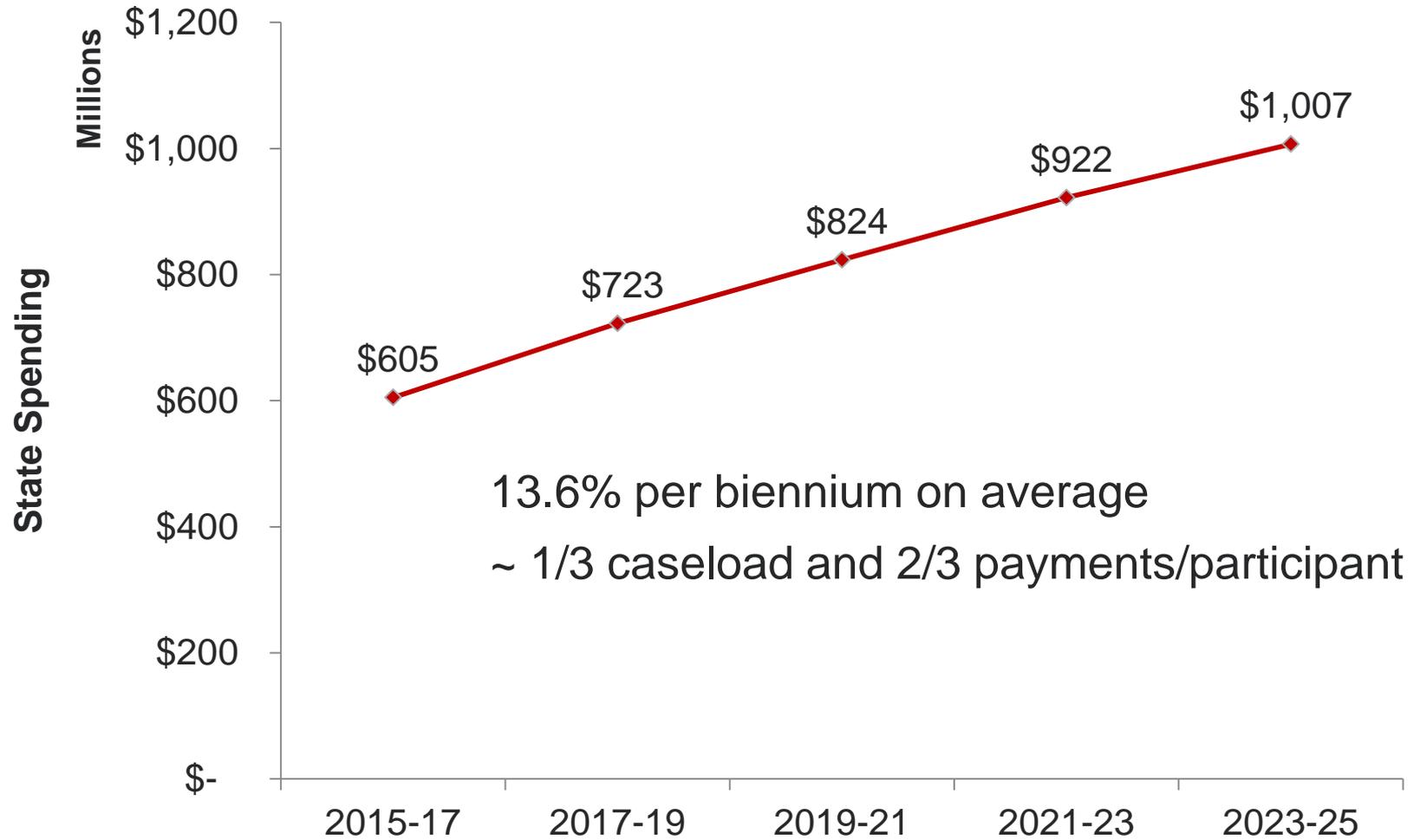
Projected State Spending for APD



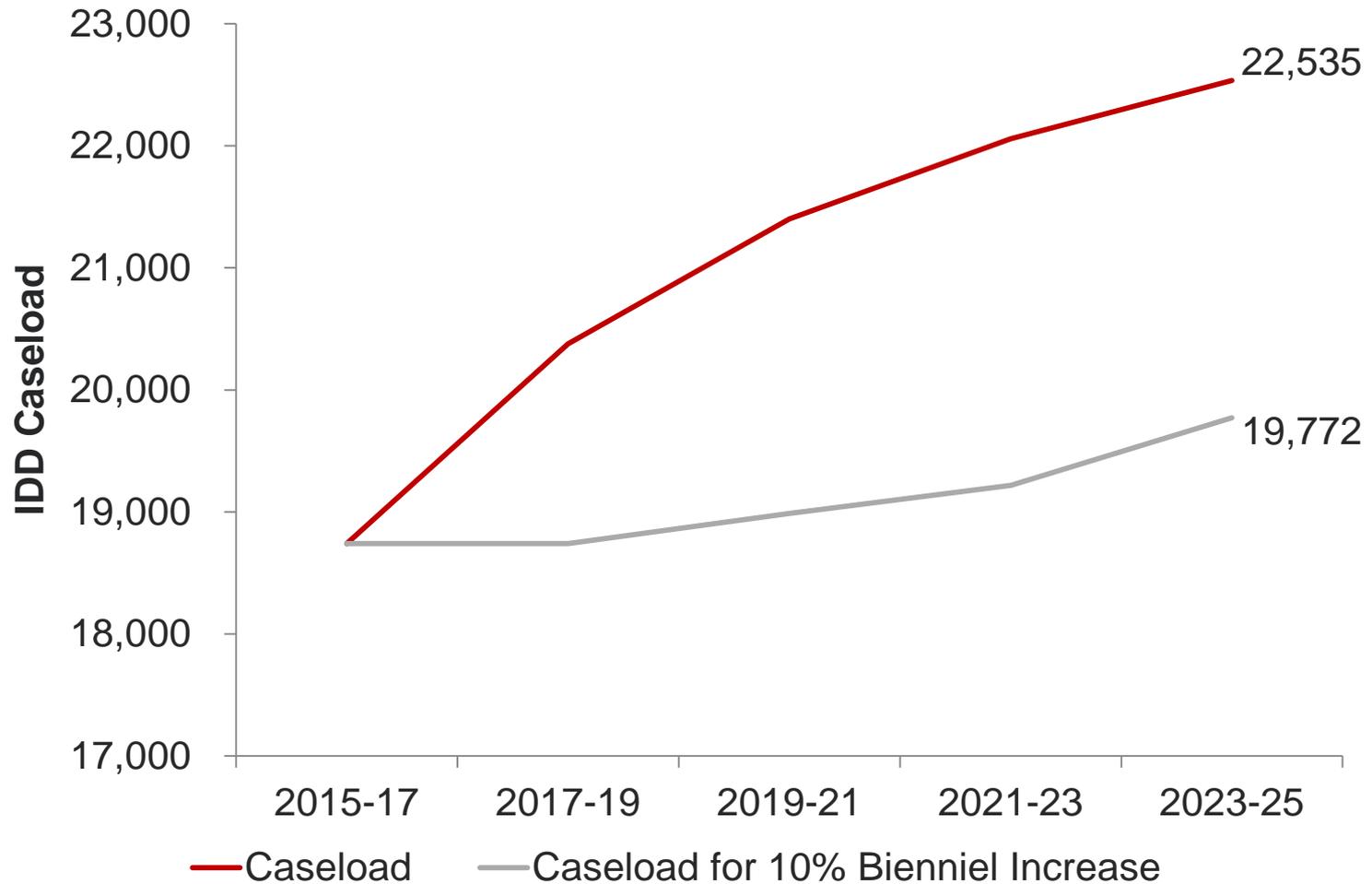
Needed Change in Caseload for APD to Constrain to +10% Biennially



Projected State Spending for IDD



Needed Change in Caseload for IDD to Constrain to +10% Biennially



APD SCENARIO: Increased Functional Need Requirement

Current Service Priority Levels (SPL) for APD = 1-13

- **1-4:** Requires full assistance with any of following, mobility, eating, elimination, and cognition.
 - **5-7:** Requires substantial assistance with mobility and assistance with elimination and/or eating.
 - **8:** Requires minimal assistance with mobility and assistance with eating and elimination.
 - **9:** Requires assistance with eating and elimination.
 - **10:** Requires substantial assistance with mobility.
 - **11:** Requires minimal assistance with mobility and assistance with elimination.
 - **12:** Requires minimal assistance with mobility and assistance with eating.
 - **13:** Requires assistance with elimination.
-
- Modeled two scenarios:
 1. Include 1-7 only
 2. Include 1-4 only

APD SCENARIO: Increased Functional Need Requirement

Fiscal Impact

Low

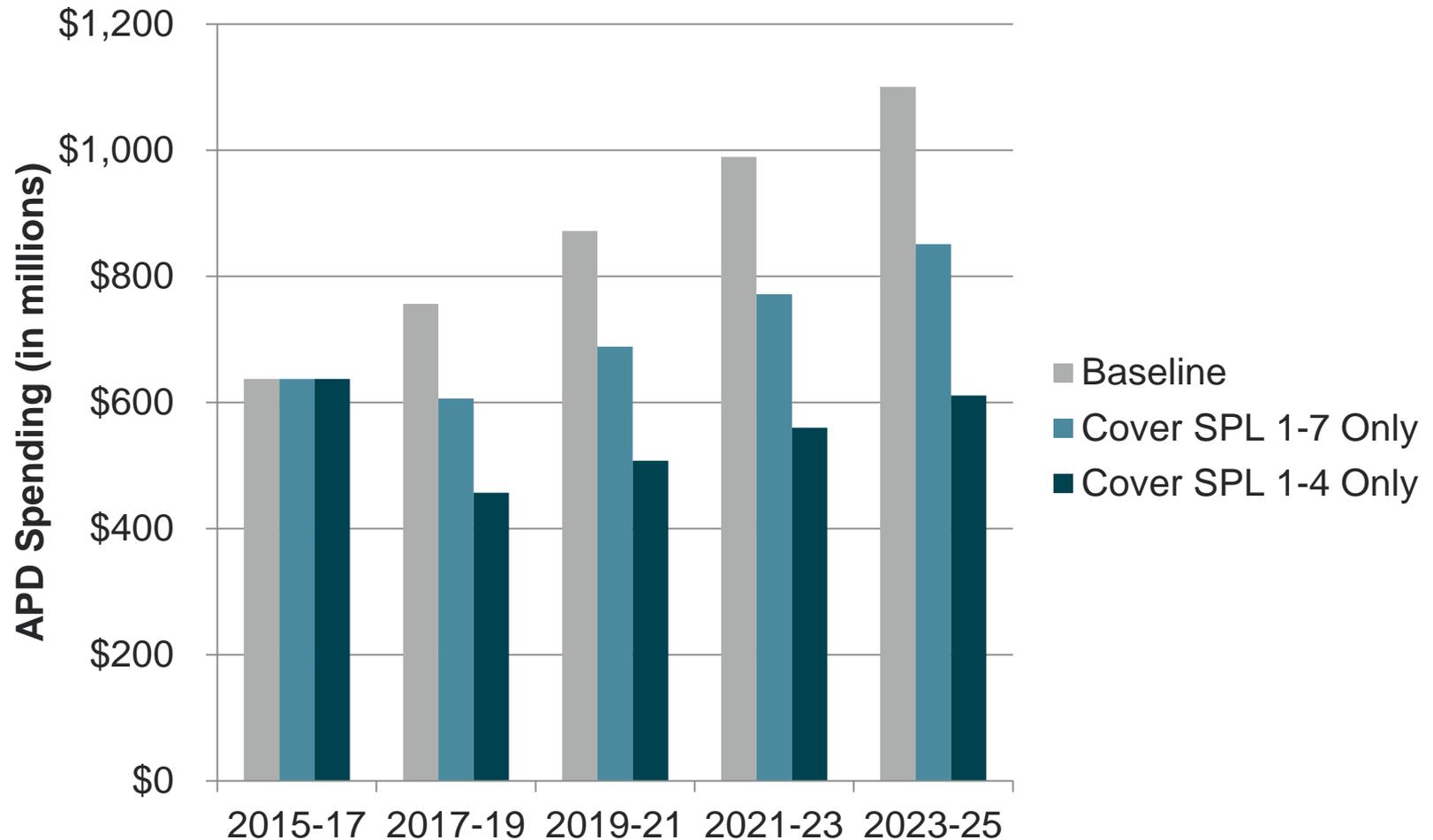
Medium

High

Fiscal impacts:

1. Fewer APD community participants resulting in one time decrease in program spending
2. Higher per participant spending because of higher acuity remaining in programs
3. Little effect on spending trend after year of decrease in enrollment

APD SCENARIO: Increased Functional Need Requirement Fiscal Impact



APD SCENARIO: Increased Functional Need Requirement

Consumer Impact

Low

Medium

High

Consumer impacts:

- SPL 1-7: ~5,400 or 18% fewer participants
- SPL 1-4: ~14,300 or 48% fewer participants
- Stakeholders overwhelmingly opposed

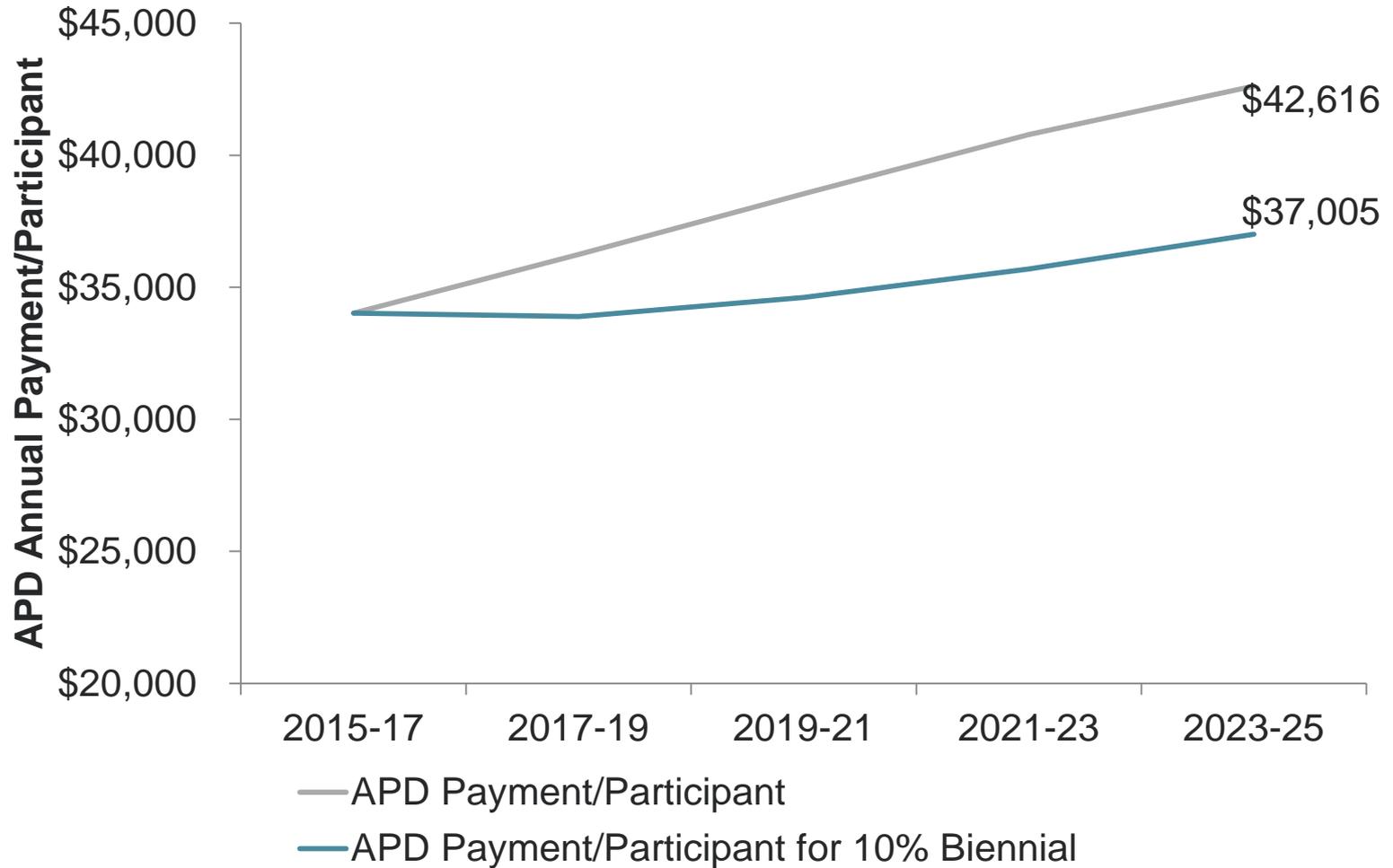
Additional Approaches to Reduce Caseload

- Return to 1915(c) authority where enrollment levels can be constrained
- Negotiate with CMS how to account for natural supports in service planning
- Change ICF/DD Level of Care criteria

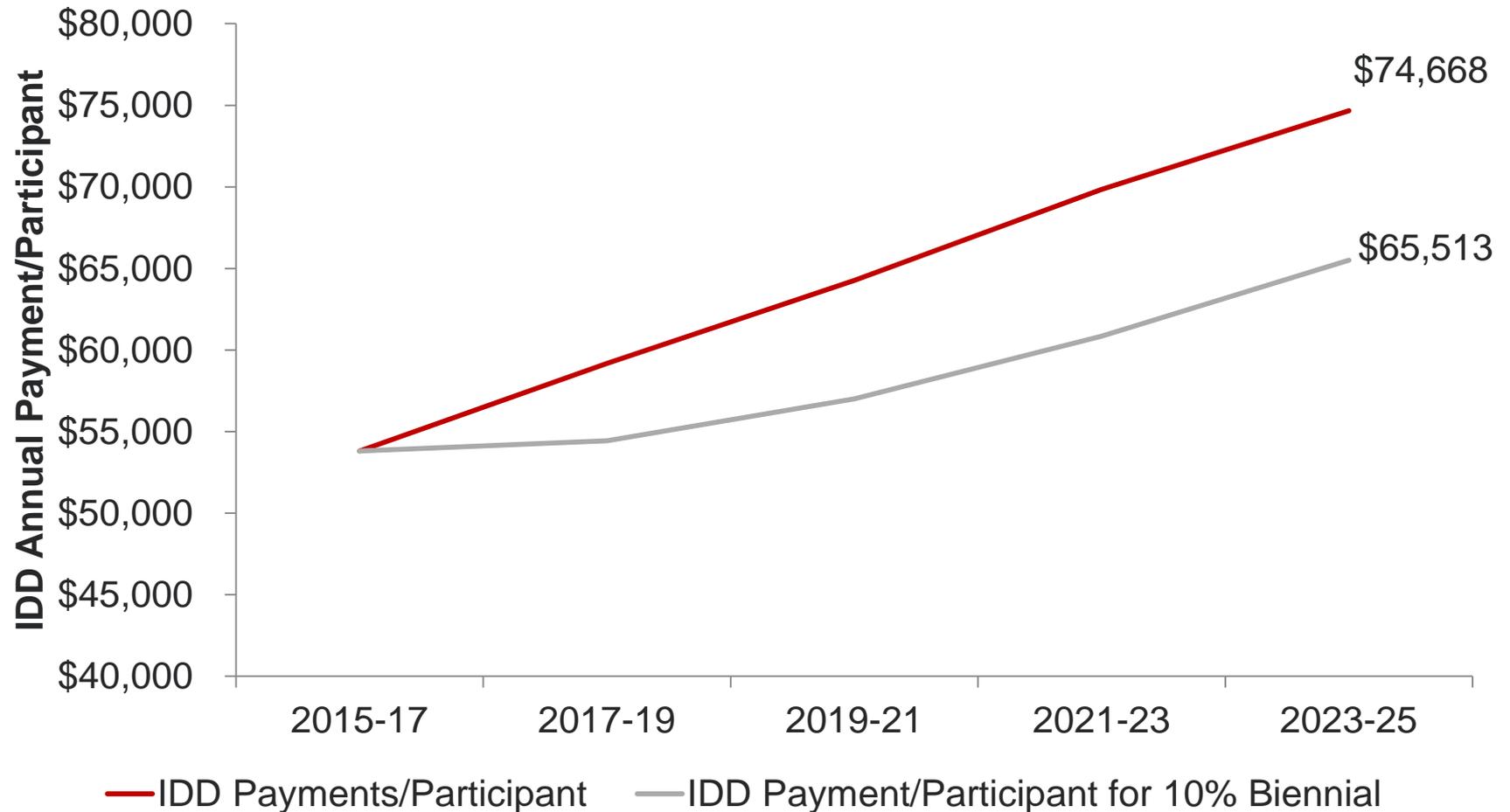
REDUCE THE AMOUNT OF SERVICES/ RATE INCREASES

1. Changes needed to meet 10% biennial increase
 - APD
 - IDD

Needed Change in Payment/Participant for APD to Constrain to +10% Biennially



Needed Change in Payment/Participant for IDD to Constrain to +10% Biennially



Approaches to Reduce Payment Per Participant

- Revisit service allocation determination by level of acuity
- Reduce the rate of increase in provider payments

CHANGE PARTICIPANT COST SHARE

1. Reduce in-home allowance

Repeal In-Home Allowance

- In 2014, new in-home allowance of \$500 to cover living expenses
 - SSI (\$733/month in 2015) + \$500/mo., or \$1,233/mo.
 - Reduced cost-share required of Medicaid HCBS users with income above SSI
- Income eligibility remains the same
 - HCBS waiver recipients allowed up to 300% of SSI or up to \$2,199/mo.
 - 150% of Federal Poverty Level = \$1,471/mo.
- Thought to contribute to a small shift from community-based care (CBS, alternative residential arrangements) to in-home care (INC) because participants can now cover living expenses
- Elimination of the in-home allowance
 - May slightly reduce the growth in in-home care users
 - Will shift responsibility for up to \$6,000 annually from the state to the participant

Repeal In-Home Allowance Fiscal Impact

Low

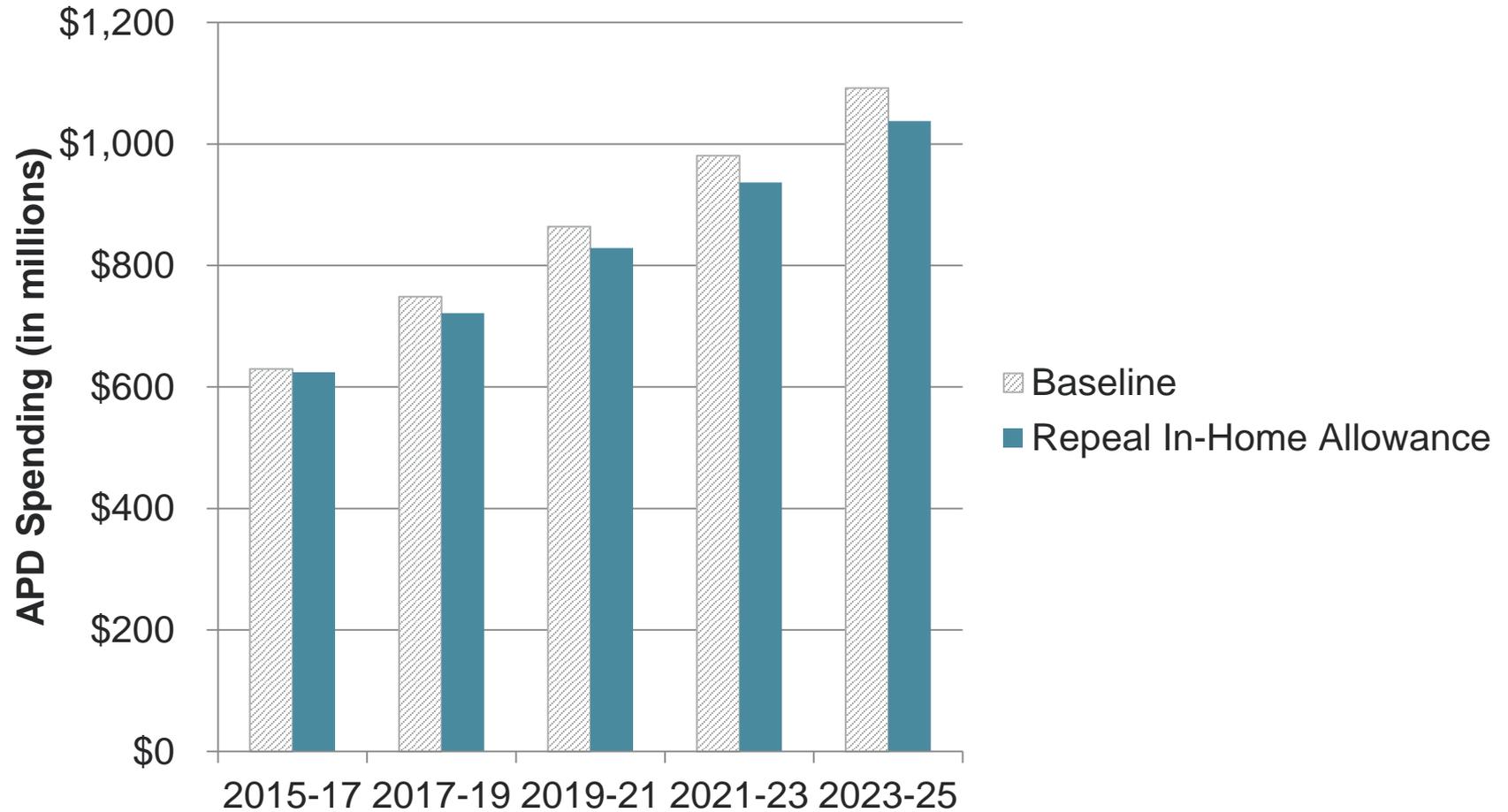
Medium

High

Fiscal impacts:

1. Reduction in state responsibility for participants with income above SSI with elimination of \$500/month housing allowance
2. Possible reduction in number of users who now do not seek in-home services because SSI level is not sufficient to cover living expenses

Repeal In-Home Allowance Fiscal Impact



APD SCENARIO: Repeal In-Home Allowance

Consumer Impact

Low

Medium

High

Consumer impacts:

- SSI income means less than \$9,000 annually for living expenses
- Housing allowance means individuals retain up to \$6,000 annually if they have income above SSI
- Eliminating the housing allowance means some participants' pay a higher cost-share, some may not enter in-home program resulting in reduced caseload, and some may chose to move into other higher cost HCBS or NF settings
- Stakeholders overwhelmingly opposed

INCREASE INTEGRATION

1. State administered managed care
2. Capitalize on CCOs
3. Contract for managed long term services and supports

Increase Integration

- Greater integration and service coordination through interdisciplinary teams between primary, acute and long-term services and supports:
 - Can provide participants better and holistic care
 - Has potential to reduce unnecessary services, particularly for acute care
 - Could result in smaller increases in spending
- Several integration models to pursue:
 - DHS and its community partners continue to manage LTC, but incorporate integration principles and training into the approach and monitoring
 - Coordinated Care Organizations
 - Keep funding separate, but Incorporate LTC into CCOs through common outcomes both CCOs and case managers held accountable related to LTC users
 - Transfer acuity and payment rate risk to managed care organizations (MCOs) by contracting for fixed capitated amounts

LEVERAGE TECHNOLOGY

1. Virtual visits
2. Remote monitoring using sensors

Recommended Next Steps/Analyses

- Analyze the distribution of participant income to better understand the implications of cost-share requirements and the in-home allowance
- Compare nursing facility residents to those receiving home and community-based services to identify any further opportunities for community placement
- Analyze IDD service allocation amounts relative to hours used in order to revisit the allocation methods
- Analyze acute and primary care, as well as pharmacy claims, to better understand the whole service use picture for LTSS participants and identify potential interventions that could improve health care and supports coordination

Summary of Scenarios Analyzed

	APD	IDD
Reduction in Caseload to Achieve 10% Biennium Spending Growth		
2023-25 Baseline Projected Caseload	45,628	22,535
2023-25 Caseload to Achieve 10% Spending Growth	39,621	19,772
Difference	-6,008	-2,763
Increasing Functional Need Requirements		
2023-25 Baseline Projected Spending	\$1,100M	NA
2023-25 Scenario Spending		
SPL 1-7	\$851M	NA
SPL 1-4	\$611M	
Difference		
SPL 1-7	-\$249M	NA
SPL 1-4	-\$489M	
Reduction in Annual Payments per Participant to Achieve 10% Biennium Spending Growth		
2023-25 Baseline Projected Annual Payments per Participant	\$42,616	\$74,668
2023-25 Annual Payments per Participant to Achieve 10% Spending Growth	\$37,005	\$65,513
Difference	-\$5,611	-\$9,155
Repeal the \$500/month In-home Allowance		
2023-25 Baseline Projected Spending	\$1,100M	NA
Additional Cost-share Collected from In-home Participants	\$1,044M	NA
Difference	-\$55M	NA

Conclusion

- Oregon has some of the most sophisticated ongoing monitoring and forecasting for its programs.
- Growing LTSS potential population as age 65+ population grows 4% annually as the Baby Boomers age
- Lewin suggests that this report serve as a starting point for further dialogue and analysis as the state continues to understand the full implications of the K Plan implementation.