

A Report on:

Long-Term Care in Oregon

**Department of Human Services
Seniors and People with Disabilities**

September 2010

Introduction

The Co-Chairs of the Ways and Means Committee of the 2009 Oregon Legislature directed the Department of Human Services to examine the future of long-term care. This followed several similar requests from both the Governor and the Legislature between 2005 and 2009.

In May 2006, the Seniors and People with Disabilities Division (SPD) released its draft report: “Recommendations on the Future of Long-Term Care in Oregon.” The report focused on seven key questions around evidence-based practices, healthy communities, preventive planning, safety net services, long-term care entitlement services and coordination between acute and long-term care services.

Much has changed in four years; yet the questions posed in the 2006 report remain largely unanswered. This 2010 report is intended to be a call to action and includes the specific steps that SPD has already taken, or plans to take, towards new thinking in the areas of community supports, acute and long-term care coordination, development of new models of long-term services and supports and the role of nursing facilities in the long-term service continuum.

The reasons to act quickly are compelling. The demographics are daunting. Of Oregon’s total population of 3.8 million people in July 2009, about 506,000 – slightly more than one in every eight people – are age 65 or older. This proportion varies greatly from county-to-county. In Washington County, the state’s youngest, only one in every 11 people is over 65. In contrast, Curry County, on the south coast, is the state’s oldest with about one of every three people over age 65.

The senior population will double over the next 20 years, to just under a million Oregonians over age 65 in the year 2030, or one in five people who live in the state. Individual county age distribution projections are equally startling. In relatively young Washington County, only 15 percent of the population, a little more than one in seven people, will be older than age 65. In northeastern Oregon (Union, Baker and Wallowa counties), fully 25 percent, or one of every four residents, is projected to be age 65 or older.

In Oregon, people 85 years of age or older make up a small but quickly growing group within the total elderly population. In 2010, about 76,000 Oregonians reached age 85. By 2030, the number of Oregonians 85 or older is expected to exceed 120,000, an increase of almost 60 percent.

Many of the aging baby boomers reaching retirement age in the next decade can be expected to live independently for many years. However, the sheer numbers of these retirees coupled with the fast growing contingent of those aged 85 and older will place an unprecedented demand on long-term supports and services, and the revenues needed to sustain the growth of such services.

The term “long-term services and supports” refers to the assistance that people need when their ability to care for themselves has been diminished due to a chronic illness or disability. The need for long-term support is often measured by how much assistance a person needs with “activities of daily living” (ADLs) such as bathing, eating or toileting, or “instrumental activities of daily living” (IADLs) such as shopping, cleaning and accessing community services. People who have limitations and need assistance or supervision with any ADLs or IADLs are said to have long-term service and support needs.

Almost all Americans will require long-term service and support in their lifetimes, either for themselves or for a loved one. It is estimated that there are about 9.5 million Americans with long-term needs, but this number is only expected to grow with the aging of the population and growing numbers of people with disabilities. Nationwide the elderly population will double by 2030, and the 85 and older population, the group most likely to have long-term care needs, will quadruple by 2050. But the elderly are not the only users of long-term care. Nearly four in ten (38 percent) long-term care users are under age 65 with some sort of physical or mental limitation. Of Americans with long-term care needs, 17 percent reside in nursing facilities while the other 83 percent live in the community, often cared for by family members.

National studies tell us that 80 percent of care giving is provided (and paid for) by the individual, family members and friends. Upwards of 30 percent of all households are involved in some kind of care giving for adults with disabilities and older persons. When people begin to look for help for themselves, their spouses, an aging parent or for a person with disabilities, they often do not have the information, skills or supports to make informed decisions. As a result, they often end up using more intense and expensive levels of care than are necessary. This is ironic since, over the course of the last two decades, there has been a dramatic increase in the amount of information, products, and options available to assist older people, people with disabilities, and their families to manage their needs.

The National Association of States United for Aging and Disabilities (NASUAD) notes: “Today, older and disabled adults and their families face a complicated array of choices and decisions about their health care, income security, insurance,

housing, financial management, and long term care. Changing benefits in public programs and an expansion of private sector services contribute to this confusing consumer climate.”

Providing help often poses special challenges for caregivers. Much of the responsibility for married older people with significant care needs falls on spouses, who are generally old themselves and perhaps coping with their own health issues. Adult children – usually daughters – often help their frail parents, but many are raising children of their own, and are employed outside the home, forcing them to juggle work and family demands. Family caregivers can feel isolated and overwhelmed, leading to high degrees of burnout and less than optimum care for the senior or person with a disability, in need of support.

The need for long-term care services and supports can impose a significant financial hardship on individuals and even lead to financial ruin. In 2009, the average daily rate charged for a semi-private room in a nursing facility in Eugene was \$214 a day – almost \$6,500 per month or \$78,000 a year. Care at home is costly, as well. In 2009, the average cost of an hour of in-home care in Portland was \$21. If a person needed four hours a day of care, five days a week, the annual cost would be almost \$22,000.

Most seniors and people with disabilities lack the financial resources to afford paid long-term care for more than a few weeks or months. Only about a third of the elderly in the community have enough resources (money in checking and savings accounts, individual retirement accounts, etc.) to pay for a year of nursing facility care. About a third have such limited resources (less than \$5,000) that they can barely afford three months of home care. Many seniors think their retirement can be financed on Social Security and learn the hard way that they did not adequately plan ahead.

Seniors who find themselves in financial trouble are frequently very embarrassed and don't know how to get help even if they had the courage to tell someone. Adult children often don't know that their parents' finances are spiraling out of control until a call comes in after the house is in foreclosure or an eviction notice has been served.

This situation has only been made worse by the historic recession of the past 18 months. While the 50+ age group is still the country's wealthiest cohort, with higher rates of home ownership and savings than younger groups, many of them are ill prepared for retirement. Nationwide personal savings are at an all time low, and many of the retirement savers age 50 and older have accumulated far less than

they will need for a retirement that could be three decades or longer. And, a mere six percent of individuals contribute to an IRA or a Roth IRA.

From January through June 2010, Oregon ranked 11th nationally in foreclosure filings – default notices, scheduled auctions and bank repossessions. One in every 76 Oregon households received a foreclosure notice during the six month period according to the Associated Press.¹

Many people still try to use their own resources to pay for needed long-term services. In 2007, about 26 percent paid for their use of Oregon nursing facilities. Private insurance pays for only a small fraction of long-term care. Private health insurance plans usually cover only a limited period of home health care and nursing facility care for people who are recovering from an illness or injury. Private insurance policies that cover the costs of long-term care are currently held by only a small percentage of Oregonians and account for a small share of spending. Medicare, which provides health insurance coverage to nearly all of the nation's elderly population, makes significant payments for home health care and skilled nursing facility care. Medicare coverage of home care and nursing facility care is closely tied to the need for acute care. Medicare pays for a maximum of 100 days of nursing facility care for people who have been recently hospitalized, and pays for home care only if other skilled services – such as nursing and rehabilitative therapy – are also needed.

People with substantial long-term care needs and limited ability to pay for care, turn to Medicaid. The federal-state Medicaid program provides a long-term care safety net for seniors or people with disabilities who are poor, or who become poor by paying for their own care. In June 2009, almost 18,400 Oregon seniors received long-term care services paid for through Medicaid. Another 8,750 adults with physical disabilities and 13,699 people with developmental disabilities also received Medicaid-paid services. Just as the need for long-term care increases with age, so does the need for financial assistance through Medicaid.

As noted in the preceding pages, the percentage of Oregonians who will need long-term care in the next 20 years will double. And, combined with the limited number who will be able to afford long-term care from their own resources, the demand for Medicaid, and Oregon's General Fund portion of Medicaid financing, will explode.

In short, the aging demographics combined with projected Medicaid spending, puts Oregon, along with most other states, on a completely unsustainable course.

¹ “A look at State Foreclosure Rates, Jan. through June”, Associated Press, July 15, 2010

This long-term unsustainability is now compounded by the current fiscal crisis facing Oregon. A revenue shortfall of over \$2.5 billion is expected for the 2011-13 biennium, with similar \$2 billion biennial gaps predicted to stretch over ten years.

Immediate Strategies to Re-Align Oregon’s Long-Term Care System

As noted earlier, most of Oregon’s long-term care system is funded with Medicaid. Although used creatively by Oregon and other states to flexibly fund home and community-based services, Medicaid comes with many Federal strings, both statutory and regulatory. Short of changing Federal law, and still working, for now, within the constraints of the Medicaid Funding Stream, DHS is working to implement three key initiatives to re-align long-term care.

INITIATIVE #1

Continue decreasing the percentage of Oregon’s long-term care budget spent on nursing facility care.

Oregon began the development of its home and community-based long-term service system in 1981. Legislative policy encouraged development of home care programs and community residential settings with nursing facility placement used only as a last resort.

In 2000, staff from the National Health Policy Forum (NHPF) visited Oregon to explore continuum of care issues and the evolution of services to seniors and people with disabilities during the 1980s and 90s - a period of rapid and fundamental change nationally. They left with positive impressions of a continually evolving system, which demonstrated “a dedication to creative solutions,” a “sense that data collection and analysis is less important than vision,” an approach that “favor(s) more consumer direction and less regulation,” and a clear sense of the importance of the case manager’s role in consumer and system success. NHPF staff also remarked that “Oregon has taken getting people out of nursing facilities as a matter of faith.”²

² Caring for the Elderly, Oregon’s Pioneers, Site Visit Report, Portland, OR, November 13-15, 2000. www.nhpf.org/library/site-visits/SV_Oregon00.pdf

Like many states, Oregon was forced to make significant reductions to its long-term service system in response to the recession in the early years of the first decade of the 2000s. State funded prevention and outreach services were eliminated; community-based care provider payments were frozen, and Medicaid eligibility thresholds were tightened. The caseload ratios in local government partners and state field offices fell far below established standards, reducing the ability of aging and disability services case managers to help clients and families navigate the long-term service and support system. And finally, enactment of a nursing facility provider tax codified a reimbursement methodology that has significantly increased the daily Medicaid rate since 2003.

One unintended consequence of these decisions was a reversal to Oregon's historic pattern of declining nursing facility utilization. Medicaid nursing facility caseloads actually grew during the first twelve months of the 2007-2009 biennium, at a rate equivalent to a five percent annual increase.

Nursing Facility Transition Services

In mid 2008, the department made the decision to re-invest in its case management system and to reinvigorate Oregon's history of helping people live in the most independent and least restrictive places possible. Dedicated transition teams were placed in every district of the state, working with consumers and their families to help people return to their homes and communities after a hospitalization or a rehabilitative stay in a nursing facility.

In response to a gradual but alarming shift in both the growth of the nursing facility caseload and the decline of Medicaid capacity in community-based care facilities, all the key long-term care stakeholders, along with key legislators, secured an interim Medicaid rate increase for community care facilities from the 2008 February special session. At the same time, SPD began to refocus resources and staff training on the critical importance of assisting and supporting individuals to return to their own homes or community-based settings subsequent to their need to utilize nursing facility care and rehabilitative services. We refer to this activity as Nursing Facility transition Services. In addition, resources and training have also been refocused to ensure individuals have information and access to case planning supportive of their preference to receive services in their own homes or community-based settings as alternative to nursing facility placement when possible. These activities are identified as nursing facility diversion tasks.

Seniors and People with Disabilities and Area Agencies on Aging partners have

reassigned or refocused staff toward the goals of the Diversion and Transition Initiative. Today, 65 staff statewide have significant portions of their time devoted to the specialized work of diversion and transition activities, and approximately 28 of those are devoted full time to this work. They are located statewide, and work in teams also encompassing pre-admission screening assessments and in some places the private admission assessment of individuals considering nursing facility placement. They work with consumers, families and natural supports to assist them with information, assistance, and access in evaluating long-term service settings and case planning options either before placement in a nursing facility occurs or to assist people to return to their own homes or community settings after a hospitalization or a rehabilitative stay in a nursing facility. To date, since mid April of 2008, the initiative has assisted over 3,000 individuals who chose to receive long-term services either by remaining in or returning to their own homes or other community-based settings.

Money Follows the Person

Oregon also secured a new Federal grant called “Money Follows the Person (MFP)”. MFP is funded by a federal grant from the Centers on Medicare and Medicaid Services (CMS). This grant was authorized by Congress in 2005 and allows states to claim a 12-month higher federal match rate for persons relocated from nursing facilities, who have lived there six months or more. The grant also allows the state to claim federal match for services that aren’t usually allowable – like housing modifications. The grant was reauthorized as part of federal health reform and the length of stay required for a person to be eligible was shortened to 90 days.

Initially, the MFP grant has helped relocate nursing home residents to adult foster homes. These fully accessible homes, located throughout the state, are contracted to serve specialized groups of former nursing home residents. The grant helps the provider with needed home modifications, durable medical equipment and assistive technology.

In the last half of 2009, CMS took another look at what constitutes a “qualified residence”³ for inclusion in MFP demonstrations. The CMS relook has offered an opportunity to partner with the state’s Assisted Living and Residential Care Facility communities to develop new living settings. New models are being

³ In order to access the additional federal match associated with the MFP demonstration projects, participants must move back to a “qualified residence” in the community.

contemplated to include people with Alzheimer's and other dementias; people with brain injuries and people whose needs are related to obesity.

New Individual Models

A new model of residential care is emerging, both in Oregon and nationally, in publicly subsidized housing communities. The model provides low-income seniors and people with disabilities with access to health-related and other supportive services, which can include long-term services and supports. These models, often referred to as Affordable Housing Plus Services (AHPS), integrate independent, and primarily subsidized multi-unit housing environments for older adults and people with disabilities with services and supports. The goal is to allow residents to remain in their housing communities even as their health declines and their disability increases.

DHS anticipates working with Public Housing Authorities (PHA) throughout the state as they respond to a Notice of Funding Availability jointly developed by the U.S. Department of Housing and Urban Development (HUD) and CMS. On April 7, 2010, HUD announced the availability of \$30 million in funding for approximately 4,000 Section 8 Housing Choice Vouchers for non-elderly disabled households. Other unobligated HUD funds are also being made available, bringing the total funds available to \$40 million for approximately 5,300 vouchers. Approximately \$7.5 million of that amount was designated to support an estimated 1,000 vouchers nationally to allow non-elderly households with disabilities to transition from nursing facilities into the community. The HUD has encouraged PHAs applying for these funds to partner with state MFP demonstration programs to identify eligible households and assist in meeting their support service needs as they transition from institutions into the community.

A group of stakeholders, including housing and services providers, advocates, Area Agency on Aging staff, representatives of housing finance agencies and SPD staff are meeting regularly to design the broad outlines of a number of proposed AHPS pilot projects in Oregon.

To date, a total of 265 clients have been relocated from nursing facilities under the MFP grant.

In the last year, the MFP grant was also amended to allow grant funding to help relocate 75-100 residents in the gero-psychiatric wards at Oregon State Hospital. These individuals, although eligible for long-term care services under Medicaid,

have remained at OSH because of severe behavior challenges that traditional long-term care settings have been unable to meet. With additional funding under the MFP grant, DHS plans new residential models with wrap-around behavioral and mental health supports to accommodate these OSH residents. In the short-run, these models will allow design of a smaller than originally anticipated state hospital at Junction City. Longer term, such models will help serve growing numbers of individuals with dementia, traumatic brain injury and other conditions which often result in behavior challenges difficult to control in current community care settings.

Care Coordination

Oregon's robust long-term service and support system is highly valued by Oregonians and regarded as a model for the nation. Oregon has also been a leader in developing managed care systems for people eligible for Medicaid. The two parallel systems, medical and long-term services and supports, operate independently of one another but serve much of the same population. Denial of important services for seniors and people with disabilities is often the result if one system believes it is the responsibility of the other to provide the service. Duplication of resources leads to consumer frustration and to inefficiencies. Additionally, the current parallel system sometimes results in the provision of a lower cost service without consideration of the higher costs caused in the other system (for example, an alternating pressure mattress is denied causing the need for 24/7 staffing to turn a person.)

As stated in an earlier section, one of the fastest growing age sub-groups is people over age 85. For these individuals changes in medical condition often precipitate costly charges in long-term care as well. Finding seamless ways to deliver coordinated acute and long-term care thus becomes a compelling agenda — with every indication that quality of life will be improved and costs better contained on both sides.

DHS is currently implementing pilot projects involving Medicaid managed care plans and SPD as the funder and coordinator of long-term care. The projects will adopt a joint care plan with a holistic view of the person's needs and a common, mutually agreed-upon set of service/care strategies.

The eventual aim is the development of a system-wide approach that holistically supports individuals who are Medicare, Medicaid, and long-term service eligible in a manner that promotes the health, well-being and choice of the individual while

eliminating the fiscal and operating barriers between long-term services and the medical system.

Better communication, coordination and alignment of incentives between long-term service and traditional medical care will result in a set of services that helps keep people safe, independent and functioning at a higher level, while protecting individual choice, keeping people in the living situations of their choice, and in the long run, saving both long-term and health care funds.

The first pilot, a partnership between SPD and Care Oregon is:

- Co-locating case workers from SPD and Care Oregon, integrated with a medical home model to provide intense, integrated case management to a small group of individuals. There will be a common, single care plan and jointly administered resources with flexibility to bend current benefit limits.
- Serving pilot populations of seniors and people with disabilities who mainly are jointly eligible for Medicare and Medicaid who are patients at a clinic that uses tenets of the “integrated health home.” While individuals in the pilot are currently eligible for nursing facility services, they have remained in the community, and live in their own homes, adult foster homes or community-based care. Participants demonstrate an increased risk of high utilization of medical services, as identified by an acuity scale.

The overall goal of this project is:

- To improve or maintain health, which includes both a person’s medical conditions and their ability to interact, function and appreciate life.
- To improve or maintain the satisfaction and well-being of clients.
- To stabilize costs or result in cost savings for the combined long-term and health care budgets. Traditionally increased coordination has resulted in increased Medicaid costs with more cost savings for Medicare, with an overall cost savings.

A rigorous evaluation by Portland State University Institute on Aging is planned to assess any differences in health outcomes associated with better collaboration in medical and long-term care case management, and assess financial benefits, if any, associated with increased investments in case management/medical management.

Discussions have also begun with other plans to expand pilots across the state, with the eventual goal of blanketing the state with long-term and health care coordination.

In the 2006 long-range plan report, DHS had proposed developing several pilots to fully bundle long-term and health care into actuarially based and capitated rates. The proposal was to emulate the success of Providence Elder Place in supporting both the long-term and health care needs of seniors under a single managed care umbrella.

Providence ElderPlace operates with a federal designation as a “Program for All-Inclusive Care to the Elderly” (PACE). It allows for bundling of all payment rates including both Medicaid and Medicare. The Providence program has consistently demonstrated exceptionally low rates of hospitalizations or nursing facility placements. Although Providence has periodically studied whether to expand the PACE model to other parts of the state, PACE remains under its federal designation, a complicated and over-regulated program.

In the models proposed by the 2006 report, DHS was looking for a PACE-like approach with more flexibility. Ultimately, the proposal was withdrawn based on widespread stakeholder concerns that client choice, a hallmark of Oregon’s long-term care system, would be sacrificed in a fully managed care environment.

The new pilots described above should prove that health and long-term care outcomes can be significantly improved through care coordination leaving the discussion over bundled rates to a later time.

The Future of the Nursing Facility

For years, the pressure has been building on the nursing facility industry to reexamine their role in long-term care, not just in Oregon, but nationally.

In October 2010, CMS will require that all nursing facility residents – regardless of who is paying for their stay – are regularly asked about their desire to return home or to a community setting. A new “Section Q” has been added to the federally required nursing facility Minimum Data Set (MDS) assessment – a tool that drives resident care planning, Medicare payment to facilities nationally, and Medicaid payment in many states, though not in Oregon. Section Q allows the resident to be part of a person-centered care planning team that focuses first and foremost on resident goals and expectations. In its manual for facility staff, CMS stresses that the goal of the Section Q is that such planning “is individualized and resident-driven.” If the resident wants to move home or to an alternate community care setting, the facility is required to initiate discharge planning and put the resident and family in touch with a local contact agency that can provide information about

services and supports available in the community. CMS emphasizes that the United States Supreme Court, in its Olmstead ruling, requires that residents who need long-term services have the right to receive those services in the least restrictive and most integrated setting possible – in other words, in their own homes and communities if that’s their choice.

The Affordable Care Act contains several provisions designed to lessen national reliance on nursing facility care. The CLASS act, discussed later in this report, will provide vested participants with enough money to pay for several hours a day of in-home help and can be used to purchase non-medical services and supports that the person needs to maintain their independence at home, or in another residential community setting. The Administration on Aging (AoA) and CMS jointly released \$60 million in Affordable Care Act grants to states and communities to help consumers and their caregivers better understand and navigate their health and long-term care options. The new grant program is expected to create streamlined, coordinated statewide systems of information; counseling and access that will help people find consumer-friendly answers to their health and long-term care needs. Areas of focus will include assisting the under-served and hard to reach with information about Medicare and Medicaid benefits, helping older adults and individuals with disabilities live at home or in settings of their choosing, assisting people transitioning from a hospital or nursing facility back into the community, and strengthening links between medical and social service systems. New payment practices will test bundling payments between acute and post-acute providers and value-based purchasing.

In 2007, Oregon’s nursing facility occupancy rate was 65 percent – lowest of all 50 states.⁴ What is the role of the nursing facility as we look to the next decade? Facilities with resources, located in the right geographic areas, have increasingly looked to specialize in high-value Medicare paid short stays for sub-acute care and for therapies. Yet many nursing facilities, particularly in rural areas, have aging physical plants not conducive to modern care practices.

There are not any easy answers. DHS and the industry should jointly explore approaches to retool unneeded capacity into more flexible models that can address area resident needs without forcing relocation away from family and friends.

Several states have explored creative Medicaid State Plan Options to use graduated rates to help buy down unused capacity – making it financially viable to modernize and convert such capacity to other uses. Oregon should explore a similar approach.

⁴ “Across the States 2009, Providers of Long-Term Care and Independent Living”, AARP.

Finally, DHS and the industry should combine efforts to complete a detailed study of nursing facility and other long-term service and support needs in each geographic area of Oregon over the next 20-30 years. And then, develop strategies to move the publicly and privately paid marketplace accordingly.

INITIATIVE #2

Develop services and supports that will keep seniors and people with disabilities safe, healthy and independent at home, as well as mitigate an early or premature spend down of personal resources and the need for publicly paid long-term care.

For the past few years, the Department of Human Services, the Oregon Association of Area Agencies on Aging and Disabilities (O4AD), and their respective stakeholders have been working to raise awareness about the shortcomings in Oregon's long-term care system and to develop strategies to enhance the services system for all Oregonians by building on the national work of Aging and Disability Resource Centers (ADRC). The goal is to enable seniors, people with disabilities and their support connections either to avoid the need for publicly financed long-term care or to minimize the scope and cost of such care.

The ADRC program is a collaborative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid services (CMS).

The shared vision is for ADRCs to become integral components of health and long-term care reform by providing information and counseling support to seniors and people with disabilities, regardless of income, to make informed decisions to meet their needs and preferences in planning for their long-term services and supports. These person-centered systems are envisioned to optimize choice and independence; be served by an adequate workforce; be transparent, encourage personal responsibility; provide coordinated, high quality care; and be financially sustainable.

Oregon's ADRC model is being developed in ways that will honor and support the desire of individuals with disabilities or who are aging to remain independent, healthy, safe and active in their home communities.

Guiding principles of this work include the following:

- **Easy to access comprehensive assistance will be available to all**, focusing on individualized needs and inclusive of diverse populations. Assistance will promote healthy living and the proactive self-management of chronic conditions. Information and assistance for seniors, people with disabilities, and their families will help people to locate appropriate services.
- **The model will be based on collaboration and community involvement.** Emphasis will be placed toward active collaboration with community partners, effective public communication and development of resources within local communities. Local stakeholder councils will help to ensure a balanced perspective, focused on quality. Customer satisfaction will be the first priority.
- **The model will promote personal responsibility and will support prevention and early intervention.** Consistent and standardized services throughout Oregon that promote personal responsibility and individual choice and allow individuals and their families to contribute based on their ability to pay will help transform the current system to meet the challenges of the future.

Federal grants for ADRCs were first made available to 12 states in 2003.

In 2008, Oregon was awarded a three-year grant from CMS to develop a prototype ADRC in Lane County. In 2009 Oregon was awarded a three-year grant from AoA to expand the work of the CMS grant to eight additional counties (Linn, Benton, Lincoln, Marion, Polk, Yamhill, Tillamook and Clatsop.) Additionally, in partnership with Multnomah County Aging and Disability Services and Washington County Department of Disability, Aging and Veteran Services, Oregon received a Community Living Program grant in 2009. Together these grant funds will be unified to create the infrastructure needed to support the ADRC model initially in the pilot areas and eventually statewide.

In moving toward the ADRC model, the involvement of consumers, stakeholders and community partners is an essential element of design and implementation. In October 2009 a statewide ADRC Advisory Council (Council) was created to provide input and oversight in planning and development of the ADRC. The Advisory Council membership represents Oregon Health Care Association, Oregon Community Colleges, Trillium Community Health Plan, Area Agencies on Aging, Senior Health Insurance Benefits Assistance Program, Oregon Alliance of Senior and Health Services, Public Health, Governor's Commission on Senior Services,

Oregon Lifespan Respite, AARP and consumers. At the February 2010 meeting, the Council agreed to contract with an outside facilitator to assist the group in developing a five year strategic plan for implementation and state-wide roll out of the ADRCs. A smaller strategic planning committee, which is more diverse demographically and geographically than the Council and in which a majority of members are consumers, began its work in June 2010, with a goal of strategic plan completion in early 2011.

Since receiving the grants, significant progress has been made in creating the foundation for the ADRCs.

- Oregon is working with an experienced vendor to create a searchable resource data base and a public facing web site, as well as a call module for ADRC staff. The target operational date is fall 2010.
- Pilot site staff are in the process of becoming certified in Information and Referral by the Alliance of Information and Referral Systems (AIRS). The certification process ensures quality and consistency in the way ADRCs share information and make public referrals.
- The ADRC brand and a strategic marketing/outreach plan that can be implemented in the pilot sites and then state-wide is being developed. This plan will be based on the Formative Evaluation that was done for the ADRC by the Community Planning Workshop at the University of Oregon. The marketing plan will be implemented winter 2010-2011 after ADRCs have been up and running a few months.
- The State Unit on Aging has contracted with Portland State University to develop and deliver Options Counseling Training Curriculum. Thirty individuals are currently taking the training with 30 more to enter training in September. Additional training will be offered in 2011.
- Lane County opened its ADRC in April 2010 and rolled out the Discharge Planning Model in collaboration with PeaceHealth. The ADRC has had 423 contacts in the three months since opening – mostly from family members and caregivers looking for information and services for their family member or client.
- Northwest Senior and Disability Services (Marion, Polk, Yamhill, Clatsop and Tillamook counties) and the Oregon Cascades West Council of Governments (Linn, Benton and Lincoln counties) are preparing to open an ADRC in early fall 2010. They are training staff for AIRS Certification and Options Counseling and working on internal operations in preparation for the ADRC.
- Multnomah and Washington counties are collaborating with Providence Portland and Providence St. Vincent Medical Centers to refer clients who

are at imminent risk of nursing facility placement for long-term care options counseling and diversion to home and community-based care alternatives. In addition they will also begin to pilot ADRC ideas within the Community Living Program grant.

The goal is that all pilot sites will be fully functioning ADRCs by January 2011.

DHS has also received a series of grants to implement healthy aging strategies. Since 2008, DHS/SPD together with community partners, has successfully applied for and received funding for seven federal grants totaling almost \$5 million. The grants are primarily aimed at keeping older adults healthy and safe at home without the need to spend down to Medicaid eligibility, and to support families in their caregiver role. Grant funds are spread across many community partners and include specific projects as follows:

- Hospital discharge planning pilot projects
- Reducing hospital readmissions
- Assistance to family caregivers supporting persons with dementia
- Evidence-based interventions to help persons self-manage chronic disease and prevent falls
- Helping low-income Medicare beneficiaries apply for low-income subsidies or Medicare Savings Plans.

Again, the thrust of all of these efforts is to assist seniors and people with disabilities to maintain healthy and active lifestyles, and to prevent or delay their need for publicly-paid long-term care.

In summary, Oregon is well on its way in implementing a state-wide network of providers and partners that will:

- Provide intensive counseling and assistance to individuals and families facing long-term care decisions; assisting them to select the most effective, low-cost solutions that forestall the need to spend down and require paid public assistance
- Assist natural family caregivers (who provide 80 percent of long-term care nationally, largely uncompensated) with information, technical assistance and limited in-home relief care
- Help seniors and people with disabilities stay healthy through evidence-based programs that will reduce both acute and long-term care costs.

INITIATIVE #3

Reduce the need for publicly paid long-term care by implementation and enrollment in the CLASS Act insurance program and explore options for expanding the purchase of long-term care insurance.

As far back as the 1990s, members of the Pepper Commission stated that the need for long-term services and supports could be treated as an “insurable event.” Increasing numbers of consumers are planning for that insurable event, and purchasing long-term care insurance. Overall numbers are still very small. By one estimate, about 385,000 new policies were sold nationally in 2007. Heightened awareness, younger buyers, reformulated products and the intensification of multi-life sales have led to a steady growth of long-term care insurance policies nationally. The industry is benefiting from heightened positive coverage within consumer print and broadcast media about the importance of long-term care planning. More importantly, many of the reports convey important information about the best ages to start planning (with a slant toward pre-retirement) and what constitutes appropriate and affordable coverage. News stories are actually telling consumers when and how to procure insurance protection.

Once primarily a senior product, buyers of long-term care insurance continue to get younger. As recently as 2000, the average policy was written on a 67-year-old. In 2007, according to American Association of Long-Term Care Insurance studies, about 83 percent of all new individual applicants were under the age of 65, while the average age was 58. As a result of the significant demographic shift, leading insurers have retooled their product offerings to address the two primary concerns of younger buyers: affordability and the concern about paying many years for something that might not be needed.

An increasing number of states, including Oregon, have implemented Qualified Partnership Plans (QPPs). A QPP provides asset protection under the Medicaid program. If a consumer receives long-term care insurance benefits from a QPP, and later needs to apply for Medicaid coverage, an amount of assets equal to the benefits paid by the QPP will not count for Medicaid eligibility and will also be exempt from collection from the consumer’s estate after death. Insurance agents must complete additional continuing education training in order to be qualified to sell QPPs. The opportunity to build sales – especially among middle-income consumers – will be predicated on the willingness and ability of the state, insurers and agents to promote the importance of LTC planning, coupled with the key benefits provided by partnership provisions.

The federal government has also taken on the insurable event as part of the Patient Protection and Affordable Care Act. Buried within the new health care overhaul is the first-ever federal insurance program to help Americans meet the often crushing costs of long-term care. The Community Living Assistance Services and Supports Act, better known as the CLASS Act, was one of the last legislative efforts of the late Senator Edward Kennedy (D-MA).

The CLASS Act is a voluntary program, designed to work like Social Security, with premiums to be deducted from workers' paychecks, unless they opt out. Enrollees become eligible for benefits after a five-year "vesting" period. Benefits will trigger for an individual when he or she is determined to have a qualifying functional limitation that is expected to last for a continuous period of more than 90 days. The Department of Health and Human Services (HHS) will determine the exact amount of premiums and benefits, and benefits will vary depending on the level of each person's disability. Benefits will be cash amounts that will be no less than \$50 per day. As of January 1, 2011, all working adults will be enrolled in the CLASS program unless they affirmatively opt out. The five year vesting period ends December 31, 2015, and the first benefits under the program will begin to be paid during the 2016 calendar year.

If the CLASS program is to truly make a dent in the expected growth of Oregon Medicaid utilization, state government should actively involve itself in the federal HHS discussions around the appropriate "carrots and sticks" to encourage participation. As an example, employers could be required to offer payroll withholding, but might also receive tax benefits for making premium contributions. Workers could be required to pay a penalty for delaying enrollment, just as with Medicare Part D today, but also allowed to buy coverage with pre-tax dollars. Given that implementation of the program is less than six months away, Oregon should make sure that it has a place at the table in the federal discussions.

Developmental Disability Services

The three initiatives on the preceding pages do not specifically call out Developmental Disability Services. However, 37 DD Clients were relocated from Eastern Oregon Training Center (EOTC) under the MFP grant. EOTC closed its doors in September 2009. And planning for Aging and Disability Resource Centers (Initiative #2) will include information and resources for DD people and their families.

More broadly, the entire DD Services System has been restructured in the last ten years. In 2000 Fairview Training Center, the last big DD institution in Oregon, closed its doors with all its residents relocated to community settings. As mentioned above, EOTC closed last year. Oregon is now one of 14 states with no institutions for this population.

Many 24-hour settings of group homes, supervised apartments, and foster homes, have been restructured to accommodate individuals with complex medical and behavioral challenges. A complete new rate setting methodology approved by CMS has been implemented tied to individualized assessments.

And to control overall costs, access to 24-hour DD services is triaged by regional crisis teams with gate keeping criteria tied to individual or family emergencies.

Finally, nearly 9,000 families with DD children and adults living at home, receive in-home supports including respite care and other staffing or adaptive equipment supports. In the last year, Oregon has closed the gap on community waiting lists, implementing the final requirements of the Staley lawsuit to support all DD adults living at home with their families. Service dollar amounts are capped to control overall costs.

In summary, Oregon's DD system is now well balanced and the envy of many states. The institutions are closed. 24-hour care access is tightly controlled. And, in-home family supports are broadly available but with tightly capped benefits and dollar limits.

Wrap-Up

Oregon's long-term care system is still recognized as one of the country's best. But, it faces daunting challenges. The aging demographic itself, both in Oregon and nation-wide as well, threatens to overwhelm the capacity and costs of both acute and long-term care systems.

In the near term, Oregon's fiscal crisis threatens to unravel Oregon's long-term care system with cost shifts and unintended consequences – and more importantly, the loss of a broad array of home and community care options consumers can choose from.

In 2003, during the last major economic downturn in Oregon, DHS reduced its long-term care budget through a series of general-fund-only program eliminations

and a series of provider rate reductions. More importantly, about 5,000 seniors and people with physical disabilities out of 28,000 were eliminated from eligibility for long-term care after securing CMS approval to change assessment levels for activities of daily living (ADLs).

In the current fiscal crisis, previously used budget reduction options are no longer available to Oregon. The big change is in eligibility requirements. In federal health reform, Congress has tied all Medicaid eligibility to pre-ARRA levels. For long-term care that means financial eligibility at the 300 percent level of SSI (about 200 percent of federal poverty level) and a diagnosis of developmental disability, or for seniors and people with physical disabilities, an assessed need for assistance in ADLs. Once having met these criteria, the senior or person with a disability, then automatically qualifies for health care as a categorically eligible person.

Now facing the 2011-2013 budget cliff, most of the General Fund programs are already gone, and eligibility cannot be changed. Accordingly, any reductions will have to be made in deep cuts to provider rates and central office and field staffing. The provider cuts will require CMS approval and only be approved based on state assurance that client access and health and safety are not compromised. And likewise, CMS will monitor staffing levels to make sure new eligibility and annual eligibility reviews are timely, licensing visits are completed regularly, and abuse investigations are prompt in protecting clients.

Finally, the biggest problem in making reductions without being able to change eligibility is that eligibility in long-term care points directly to nursing facilities. Under federal law, if a state takes any Medicaid dollars at all, it must provide a mandatory nursing facility benefit. In short, if Oregon's in-home and community care system falters, the migration into nursing facility settings at two to three times the cost cannot be stopped — at least cannot be stopped without jeopardizing the operation of the entire state Medicaid program.

What can be done? Short of changing eligibility, the only alternative is a mechanism whereby Oregon can control the scope and duration of the type of Medicaid long-term care service offered, and an ability to assign the person to the least expensive setting.

Oregon needs to explore two possible options. One is an 1115 super Medicaid waiver. Typically called research or demonstration waivers, 1115 waivers give CMS broad authority to waive many of the requirements that otherwise constrain most Medicaid waivers or state plan options (the Oregon Health Plan is funded under an 1115 waiver). If Oregon can't change eligibility for long-term care, but

must significantly reduce costs, the 1115 authority might provide opportunities to at least limit the amount or scope of long-term care services.

Another possible approach is the Center for Innovation embedded in the Affordable Patient Care Act. Preliminary discussions with CMS indicate this center may likewise have broad authority to waive traditional Medicaid and Medicare requirements.

Both of these options have to be seen as still tentative at this point since CMS has yet to issue major policy transmittals or regulations on how federal health reform provisions will be applied to long-term care.

For better or for worse, Oregon's fiscal crisis will certainly re-shape the future of long-term care in this state. But, even beyond the current crisis, long-term care systems across the country will be severely challenged in terms of capacity and costs. Accordingly, the key recommendations detailed in this report need to be fully implemented.