

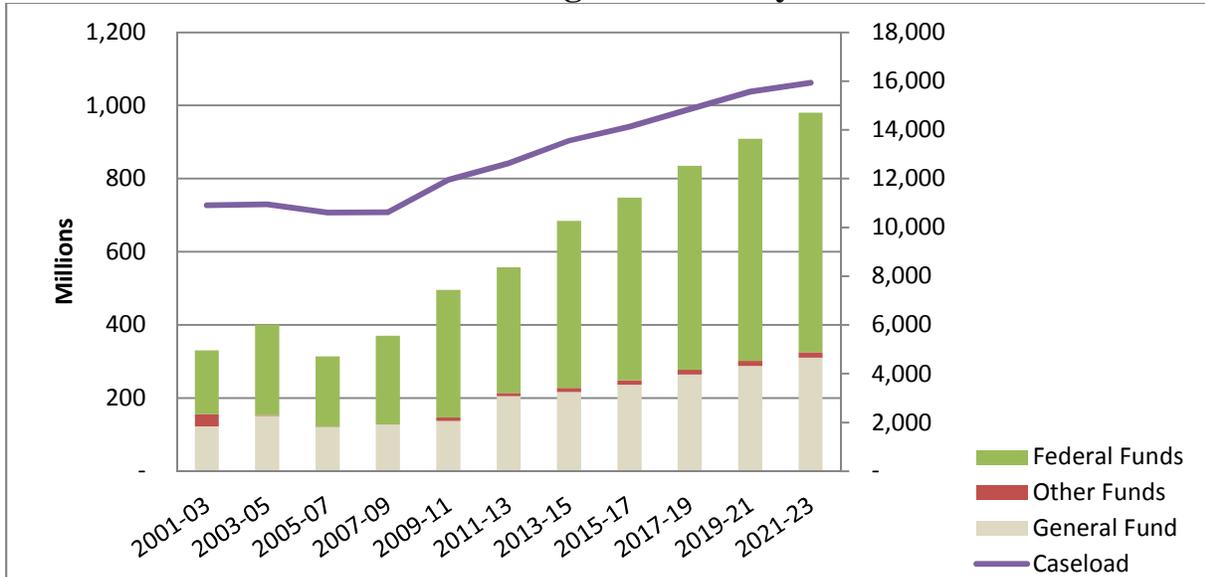
Department of Human Services: Community-Based Care

Aging and People with Disabilities

Primary Outcome Area:
Program Contact:

Healthy People
Mike McCormick, 503-945-6229

Access and Funding: Community-Based Care



Note: Caseloads dropped after the elimination of certain eligibility groups in 2003. Access to care was challenging when a robust private pay market existed in the mid-2000s. An investment by the Legislative Assembly in 2008 strengthened access considerably.

Executive Summary

Community-based care is considered the middle layer of Oregon’s long -term care continuum and includes a variety of 24-hour care settings and services for low-income seniors and people with disabilities who cannot meet their own activities of daily living. These services are part of Oregon’s nationally recognized home and community-based care system, which provides a critical, cost-effective alternative to nursing facilities.

Program Funding Request

	CBC			
	GF	OF	FF	TF
LAB	204,886,330	9,336,468	343,010,692	557,233,490
ARB pre Medicare a/b move	216,841,315	10,626,489	457,454,225	684,922,029
ARB after Medicare move	216,841,315	10,626,489	457,454,225	684,922,029
Difference without move	11,954,985	1,290,021	114,443,533	127,688,539
Percent Change from LAB	5.8%	13.8%	33.4%	22.9%

Significant Proposed Program Changes from 2011-13

Aging and Physically Disabled Investments/Reductions	CBC			
	GF	OF	FF	TF
Decrease Nursing Facility Caseloads through Diversion/Transition Initiatives	6.89	0.40	11.48	18.76
Elect State K Plan option to add 6% match for Community Facilities	(33.98)	0.00	33.98	0.00
Increase Home and Community-Based Care rates after 5 years of flat rates	11.00	0.00	24.00	35.00

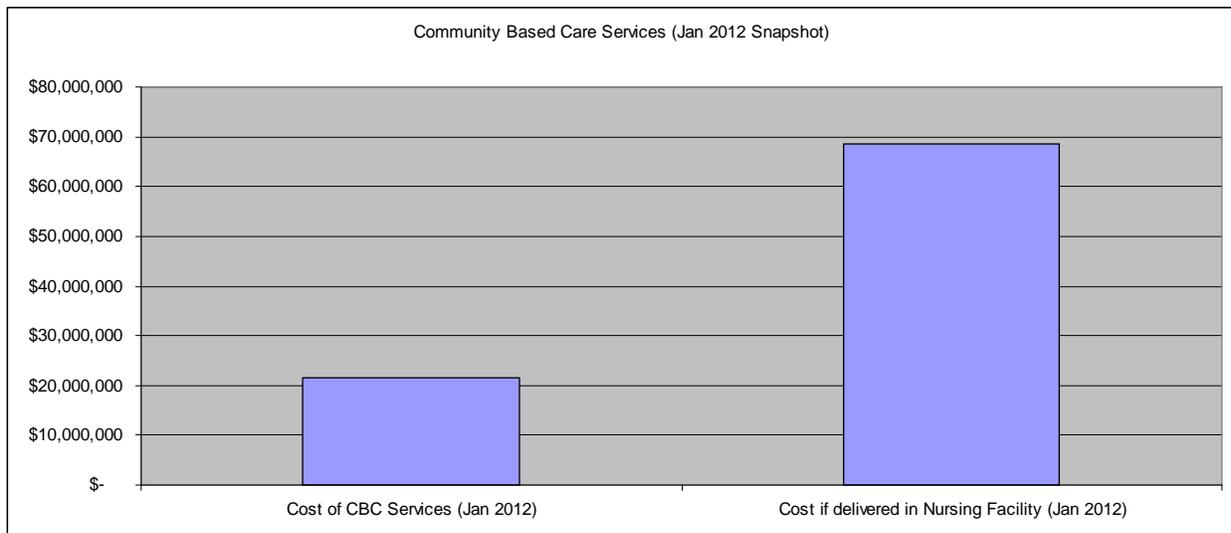
(\$, millions)

Proposed changes from 2011-13 include electing the state “K” plan to add an additional 6 percent federal funds match. This budget would see increases paid for by savings from efforts to reduce nursing facility caseloads to more appropriate and cost effective services. Finally it is proposed to provide an increase in community based care rates after 5 years of flat rates.

Program Description

Community-based care provides a critical alternative to nursing facilities for seniors and people with disabilities who cannot meet their own daily needs. The State of Oregon strives to meet the needs and expectations of increasingly culturally and ethnically varied populations.

Eligibility for long-term care services is based upon a combination of financial condition and service needs. Recipients contribute their own funds towards room and board directly to community-based care facilities while the state pays for services, mostly consisting of assistance with Activities of Daily Living (walking, transferring, eating, dressing, grooming, bathing, hygiene, toileting, and cognition) and Instrumental Activities of Daily Living (meal preparation, housekeeping, laundry, shopping, medication, and oxygen management). Nursing facility care is a guaranteed Medicaid benefit to eligible individuals. If the State did not use alternatives to the nursing facility level of care, more than 13,000 individuals would likely be receiving services in nursing facilities at more than 300 percent of the cost. The following table illustrates hypothetical costs that would have been incurred in January 2012 if community-based care services were not available.



Community-based care includes:

- Adult Foster Homes which serve five or fewer individuals in a home-like setting;
- Residential Care Facilities (RCF) which serve six or more individuals in a facility with private or shared rooms and common areas;
- Assisted Living Facilities (ALF) which serve individuals in their own apartments;
- Enhanced Care Services which serve individuals with significant limitations complicated by mental health needs. This program is jointly funded between DHS and the Oregon Health Authority's Addictions and Mental Health Program;
- Program of All-Inclusive Care for the Elderly (PACE) which serves nearly 1,000 individuals via a fully capitated premium. The program is jointly funded with Medicare and Medicaid dollars and provides an integrated program for medical and long-term services. Individuals are aged 55 and older, generally attend adult day services and live in a variety of settings representative of Oregon's long-term care continuum. Oregon's only PACE provider, Providence Elderplace, is responsible for providing and coordinating its clients' full health and long-term service needs in all of these settings.

DHS competes with the private pay market for access to most community-based care. Most facilities have a mix of private pay and Medicaid residents. Medicaid residents account for 41 percent of all occupancy in Assisted Living Facilities and 39 percent in Residential Care Facilities. Medicaid access to community-based care is currently strong, despite the fact that Medicaid rates are generally 10 to 20 percent lower than comparable private pay rates. When economic conditions strengthen, and as our society ages, DHS may lose access as competition for open beds will increase.

Adult foster homes recently organized and elected SEIU as their collective bargaining representative. Factors such as safety and quality cannot be negotiated; however, issues such as training and service rates are mandatory subjects of bargaining.

Each community-based care setting must meet Federal and State laws and regulations related to health, safety and service delivery. Mandatory services include assistance with activities of daily living, medication oversight and social activities. Some settings, which serve individuals with more complex needs, may include additional services such as nursing and behavioral supports.

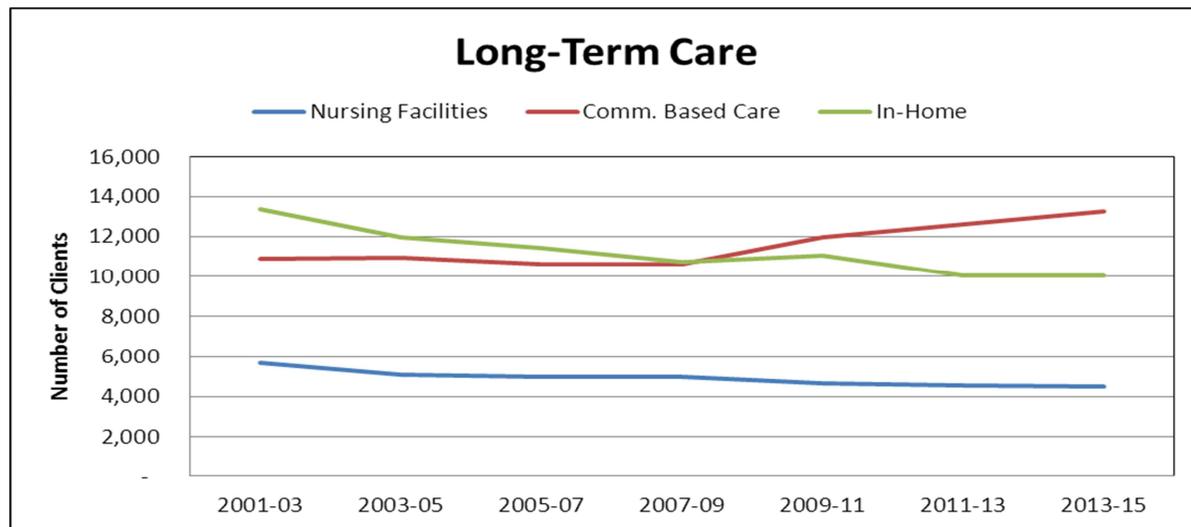
Program Justification and Link to 10-Year Outcome

Community-based care is a direct link to the Healthy People Outcome area that Oregonians are healthy and have the best possible quality of life at all ages. The program maximizes Federal resources while reducing unnecessary costs in higher levels of care. With one of the lowest levels of nursing facility utilization in the country, Oregon is at the forefront of using community-based care as a core alternative to nursing facilities. With ongoing support, Oregon can meet the target of serving 90 percent of publicly funded long-term care caseload in home and community-based care in the next 10 years (up from 82 percent).

Program Performance

A key DHS goal is that people are safe and living as independently as possible. DHS currently measures this goal based on the percentage of individuals living in their own homes in lieu of a licensed care facility, as well as the percentage of individuals who move to a less restrictive

service setting such as community-based care. Currently, there are more individuals participating in the Medicaid program who reside in community-based care settings than there are receiving services in a nursing facility, as demonstrated in the graph below.



Aging and People with Disabilities is currently in the planning process to reform and modernize Oregon’s publicly funded long-term care system. This involves identifying innovative strategies to increase the percentage of individuals receiving in-home and community-based services.

Community-Based Care service plans have been proven to be a cost-effective alternative to nursing facility care. Costs range by facility type and assessed need of the individual. The monthly average cost by setting is:

- Adult Foster Homes \$1,978;
- Residential Care Facilities \$1,468; and,
- Assisted Living Facilities \$2,089.

The cost of similar services provided in a nursing facility exceeds \$6,000 per month.

Enabling Legislation/Program Authorization

Community-Based Care is operated under a 1915 (c) waiver. The State provides services that waive against nursing facility services, the mandated benefit for Medicaid eligible individuals under Title XIX of the Social Security Act. Additionally ORS 410 and ORS 443 provide statutory policy and structure to the services offered.

Funding Streams

Community-Based Care services are funded through the Medicaid program. Therefore, the Federal government pays approximately 63 percent and the State pays 38 percent. There is a small amount of funding from the estates of former recipients. When a Medicaid recipient dies, we are required by Federal law to recover money spent for the individual's care from the recipient's estate. These funds are reinvested in services for other individuals, offsetting the need for General Funds.