Department of Human Services: Other Services
Aging and People with Disabilities

Primary Outcome Area: Healthy People
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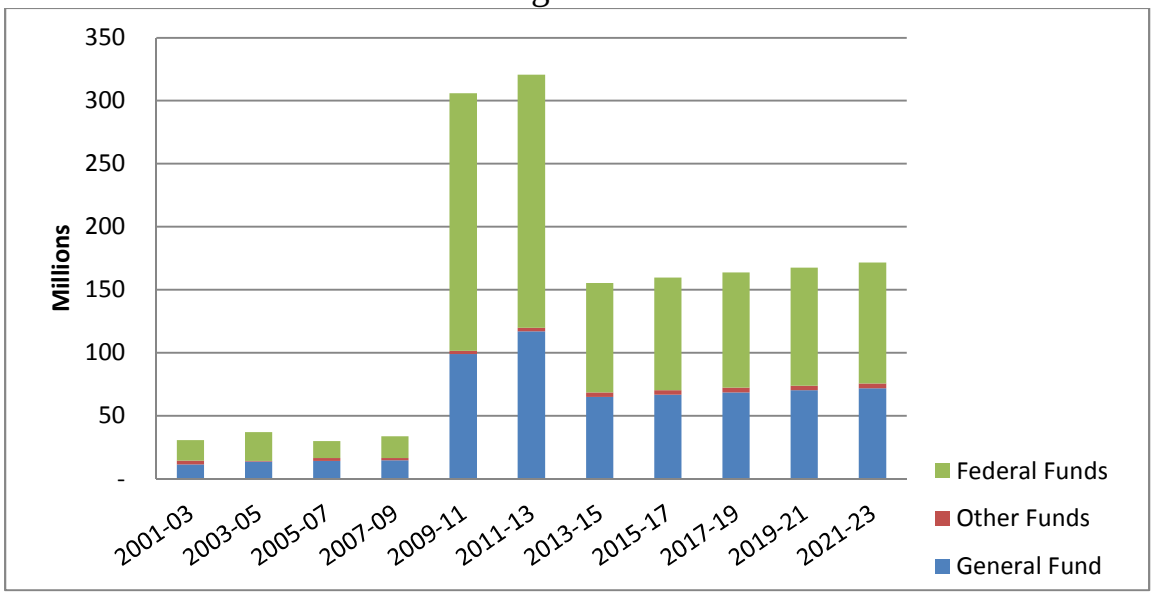
Funding for Other Services



Note: This chart shows a glance at funding streams over the biennium. More detail will be given in the presentation round.

Executive Summary

Aging and People with Disabilities provides federally mandated programs, such as the Medicare Buy-in and the Medicare Part D through Other Services. These low income subsidy programs help low-income Medicare beneficiaries meet their cost sharing requirements. This cost-effective investment ensures that Medicare remains as a first option for payment, thereby reducing or eliminating costs to the State's Medicaid health programs (Oregon Health Plan). Other Services also includes programs that support individuals living as independently as possible in the community. For example, home-delivered meals provide a critical support to many individuals who otherwise may not be able to remain independent in their own home.

Program Funding Request

	Other APD Programs (includes Medicare Part A/B premiums			
	GF	OF	FF	TF
LAB	117,180,193	2,663,903	200,796,081	320,640,177
ARB pre Medicare a/b move	184,947,868	3,493,070	298,330,500	486,771,438
ARB after Medicare move	65,144,167	3,493,070	86,816,958	155,454,195
Difference without move	67,767,675	829,167	97,534,419	166,131,261
Percent Change from LAB	57.8%	31.1%	48.6%	51.8%

Significant Proposed Program Changes from 2011-13

	Other APD Programs			
Aging and Physically Disabled Investments/Reductions	GF	OF	FF	TF
Elect State K Plan option to add 6% match for In-Home programs	(4.34)	0.00	4.34	0.00
Add capacity to meet mental health needs and reduce # served at OSH	12.49	0.00	9.65	22.13
Add capacity for high needs clients to transition out of Nursing Facilities	1.98	0.00	3.30	5.29
Create APD Innovation Fund to test ideas to lower cost and increase quality	9.00	0.00	0.00	9.00
Create DHS/OHA Caseload Contingency Fund	10.00	0.00	16.66	26.66
Move Medicare Part A/B Buy-in to OHA to better align program to policy area	(119.80)	0.00	(211.51)	(331.32)

($, millions)

Caseload and cost per case increases drive a significant part of the pre-Medicare A and B move budget. DHS and OHA propose the move of the Medicare Part A and B premium payment program funding from DHS to OHA. This will have a net $0 impact to the state and is intended to move the program closer to the policy area. Savings from selecting the state "K" plan option is then strategically reinvested to help build a sustainable system ready to address the inevitable aging population and to support systems to prevent individuals from needing long term care in the first place. This includes:

- Increase available space to meet the needs of aging or people with disabilities who have mental illness. Current facilities are at capacity and have waiting lists and additional capacity is necessary to serve the growing, unmet needs. Transition aging residents who suffer from traumatic brain injuries, dementia or other brain syndromes currently served in the Oregon State Hospital to less expensive, non-institutional community care which is more cost effective.

- Support for special population capacity development through specialized living settings for individuals where service gaps exist. For example, individuals who are bariatric, require multiple individuals to assist with transfers or those on a ventilator. These individuals are currently served in nursing facilities or other institutions at a high cost. This investment would be matched with federal funds, to create additional service settings and provider supports for individuals to transition out of institutional settings and be served in the community in a more cost efficient way and a better quality of life.

- Using an innovative approach to long term care services helps us prepare for the increase in our aging populations. Initiatives will serve Medicaid, pre-Medicaid and non-Medicaid populations. Innovations and pilots will be tracked and outcomes measured leading to the statewide adoption and implementation of new evidence-based approaches that increases the efficiency and effectiveness of services. The implementation of successful pilots will re-establish Oregon as a nationwide leader in its field.

- Our caseloads fluctuate and change depending on several factors. DHS recommends funding a $10.0 million dollar General Fund caseload contingency fund set aside in case of significant unforeseen caseload or cost per case changes.

Program Description

The majority of funding in Other Services is dedicated to the Medicare Buy-in programs that support low-income individuals in accessing their Federal Medicare benefits. Federal law requires states to provide payments for Medicare beneficiaries who meet specific income guidelines. Medicare beneficiaries include individuals aged 65 or older and people with disabilities who have been receiving Social Security Disability payments for at least two years. The passage of the Medicare Improvements for Patients & Providers Act (MIPPA) of 2008 expanded the asset allowance and eliminated the estate recovery component of Medicare Savings Programs. These changes eliminated many of the barriers to the Medicare Buy-in programs for a significant number of Oregonians.

Oregon is expected to serve over 105,000 seniors and people with disabilities in the following programs:

- **State Medicare Buy-in:** By purchasing Medicare Part B (which has a Federally required premium) for individuals eligible for both Medicare and Medicaid (dual-eligibles), the Medicaid program pays for medical services such as physician, radiology and laboratory services, only after Medicare has paid as primary payer.
- **Medicare savings programs:** Clients in these programs receive Federal mandated assistance with their Medicare Part B premiums. Specified low-income Medicare beneficiaries and qualified individuals are those individuals who have income between 100 and 135 percent of the Federal Poverty Level (FPL).
- **Qualified Medicare Beneficiaries:** Beneficiaries receive State assistance for the costs associated with the Medicare hospital benefit, Part A, and physician services, Part B, that would otherwise be required of them, including premiums, deductibles and co-payments. These clients have income equal to or less than 100 percent of the FPL.
- **Medicare Part D:** Those who receive Medicare Part B premium assistance are eligible for Medicare Part D, the Medicare pharmacy benefit. All clients in the Medicare Buy-in programs receive assistance from CMS with their Medicare Part D premiums and co-insurance amounts. Oregon pays a per-person monthly premium to Medicare for eligible clients.

Other Services also includes services that support individuals in their own home. These supports reduce reliance on nursing facilities and licensed community-based care while simultaneously improving quality of life and saving taxpayers money. These programs provide supplemental services as needed to in-home clients and are not tracked as a separate caseload. These programs include:

- **Medicaid Adult Day Services:** Adult day services provide supervision and care for adults with functional or cognitive impairments who cannot be left alone for significant periods of times. Services may be provided for half or full days in stand-alone centers, hospitals, senior centers and licensed care facilities.
- **Medicaid In-Home Agency Services:** As an alternative to performing the employer duties required in the client employed Home Care Worker program (detailed in the In-Home Services bid form), many clients prefer to receive their in-home services from a home care agency. Home care agencies employ, assign and schedule caregivers to perform the tasks authorized by the client's case manager. APD contracts with licensed in-home care agencies throughout the state, although they are not available in every area.

Agencies work closely with local case managers and clients to ensure services are provided as authorized and also to ensure the quality of the work performed.

- **Medicaid Home-Delivered Meals:** Home-delivered meals are provided for Medicaid eligible clients receiving waivered in-home services who are homebound and unable to go to the congregate meal sites, such as senior centers, for meals. These programs generally provide a mid-day, hot meal daily and often frozen meals for days of the week beyond the provider's delivery schedule.

- **Medicaid Personal Care Services:** These services are available to people who are Medicaid eligible but not eligible for waivered in-home services. Services are limited to no more than 20 hours a month. Personal care can be used only for tasks related to the performance of activities of daily living, such as mobility, bathing, grooming, eating and personal health assistance. These services can be invaluable for individuals with short-term condition that requires some assistance performing activities of daily living.
- **Cash payments:** APD makes special-needs payments to reduce the need for more expensive long-term care payments and to allow a client to retain independence and mobility in a safe environment. Special needs payments may be used for such things as adapting a home's stairs into a ramp or repairing a broken furnace. Clients can also receive cash payments to help pay Medicare Part D prescription drug copays, payments for non-medical transportation, and a one-time emergency payment for an unexpected loss (such as stolen cash, a car repair or a broken appliance). The budget supporting these payments meets the federal requirement for APD's maintenance of effort (MOE).

Program Justification and Link to 10-Year Outcome

Other Services are targeted supports that help Oregonians remain in the least restrictive setting possible. The department strives to provide services in a respectful, culturally and linguistically appropriate manner. These services are directly tied to the Healthy People Outcome area and help ensure that "Oregonians are healthy and have the best possible quality of life at all ages." They also tie to Strategy 1 on changing how health care is delivered in Oregon by supporting efforts to increase home and community-based care to 90 percent of the total Medicaid long-term care caseload. The 10-Year Outcome also envisions an integrated system that these community supports will help realize.

These services allow individuals to receive services at the right time and in the right place. They maximize Federal funding by using Federal Medicaid funding to provide person-centered services when the person needs them. It ties directly to the desired outcome of "ensuring financial stability for the long-term care service systems and supports."

Other Services complement and enhance in-home service plans, contributing to overall cost-effectiveness and the sustainability of the plan. Other Services not only haves a positive impact on consumers, but also their natural support system (relatives/friends/neighbors), preventing burn-out and the need for higher cost services.

Program Performance

In an independent study conducted by AARP, Oregon received an overall ranking of 3rd out of 50 states in terms of affordability and access, choice of settings and providers, quality of life and

quality of care, and supports for family caregivers. With approximately 40 percent of the Medicaid caseload served in their own homes, Oregon continues to rank in the highest percentile.

Enabling Legislation/Program Authorization

Services in this category are operated under both the Medicaid State Plan and Oregon's Home and Community Based Care 1915 (c) waiver. The State provides services that "waive" against nursing facility services, the mandated entitlement 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

Other Services are mostly 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 that is State General Fund only, which serves to meet the State's Maintenance of Effort requirements. Finally, 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.