

Department of Human Services

AGING AND PEOPLE WITH DISABILITIES Program

MISSION

The Department of Human Services Aging and People with Disabilities (APD) program assists seniors and people with disabilities of all ages to achieve well-being through opportunities for community living, employment, family support and services that promote independence, choice and dignity.

GOALS

We help aging and people with disabilities:

- remain as independent as possible;
- sustain the supports needed to maintain quality lives in their home communities;
- honor choices made by them about their own lives;
- by promoting value-driven commitments in statute and policy; and
- by partnering with advocacy groups, commissions and councils, local government partners, and community organizations.

Individuals we serve

During the 2011-13 biennium, we expect to serve approximately:

- 2,000 people age 60 and older through Oregon Project Independence.

- 28,000 aging and people with physical disabilities with long-term care services paid through Medicaid.
- 380,000 aging individuals with Older Americans Act services.
- 150,000 through direct financial support services.

APD and Area Agencies on Aging (AAA) employees throughout Oregon are responsible for providing direct client services through a network of local offices. Employees also determine eligibility of aging and people with disabilities for medical programs provided through the Oregon Health Authority (OHA)

Medicaid Services

More than 27,000 aged and physically disabled Oregonians currently use Medicaid long-term services each month. By federal law, each state must develop criteria for access to nursing facility care paid by Medicaid. Criteria must include financial and asset tests as well as service eligibility criteria. The federal government, through CMS, must approve any criteria established by the states.

DHS created service priority levels (SPLs) to establish eligibility for Medicaid long-term services. SPLs prioritize services for aging and people with physical disabilities whose well-being and survival would be in jeopardy without services. Level 1 reflects the most impaired while Level 17 reflects the least impaired; levels are based on the ability of the person to

perform activities of daily living (ADLs). Because of budget constraints, only level 1-13 are funded. ADLs are personal activities required for continued well-being. These include eating, personal hygiene, cognition, toileting and mobility. For many individuals with disabilities, they need assistance from other people to perform daily activities, APD assists thousands of Oregonians who require ADL services in selecting competent providers and establishing effective working relationships with those service providers.

PROGRAMS

APD's budget is sectioned into three key areas; program services, program design, and program delivery.

Program Services

Services focus on supporting fundamental activities of daily living (ADL), such as bathing, dressing, mobility, cognition, eating and personal hygiene. Long-term services ensure that the person is living in a safe and healthy environment. All services promote choice, independence and dignity. Services can be provided in nursing facilities, or community settings such as residential care facilities, foster homes, or in the person's own home. Services are provided through five programs:

- Older Americans Act
- Direct financial support
- In-home services
- Community-based care facilities
- Nursing facilities

Older Americans Act

This is a federal program and is administered through APD. It provides federal funding for locally developed support programs for individuals ages 60 and older. APD distributes funds to local Area Agencies on Aging (AAA's) for service delivery through subcontractors. Nearly 400,000 Oregonians accessed these services in 2011. AAA's develop services that meet the needs and preferences unique to individuals in their local area. Program mandates require services target those with the most significant economic and social need, to minorities and those residing in rural areas. There are no income or asset requirements to receive services except those related to the Older Worker Employment Program.

APD distributes federal funds to the AAA's using a federally approved intra-state funding formula based on the demographics and square mileage of each area. Programs might include; family caregiver supports, medication management, nutrition via congregate and home-delivered meal programs, senior employment, legal services or elder abuse prevention services. They may also provide assistance to senior centers and sponsor and promote evidence-based wellness and chronic health condition management activities.

Direct financial support

Programs are designed to meet a variety of special circumstances for certain low-income populations.

Cash payments – special needs

APD is required to meet a maintenance of effort (MOE) payment for low-income aged and disabled Oregonians who receive federal Supplemental Security Income (SSI) benefits. These benefits are focused on payments that allow clients to

retain independence and mobility in a safe environment. Examples of Special Needs Payments include; help for non-medical transportation, repairs of broken appliances such as a furnace, or for such things as adapting a home's stairs into a ramp.

Employed Persons with Disabilities Program (EPD)

This program allows people with a disability to work to their full extent and not lose Medicaid coverage. To be eligible, a person must be deemed disabled by Social Security Administration (SSA) criteria, be employed and have adjusted income of less than 250% Federal Poverty Level (FPL). Eligible individuals pay a monthly participation fee and are eligible for the full range of Medicaid benefits and services.

Other benefits

The Centers for Medicare & Medicaid Services (CMS) requires DHS to coordinate with Medicare in many areas and clients need help accessing other programs for which they are eligible. The federal Medicare program is the most common program clients need assistance with. APD determines client eligibility and submits client data to CMS for two Medicare-related programs: Medicare buy-in and Medicare Part D low-income subsidy. APD served nearly 120,000 clients in these two programs over one year. These programs help low-income beneficiaries with their cost sharing requirements. Securing this coverage also ensures Medicare remains in a "first payor" status, ultimately saving the State's Medicaid program significant money.

Medicare buy-in programs

Federal law requires states to provide payments for Medicare beneficiaries who meet specific income guidelines. Medicare

beneficiaries are people aged 65 and older, as well as younger individuals who have been receiving Social Security Disability Insurance (SSDI) payments for at least two years. APD served more than 90,000 seniors and people with disabilities in the following Medicare buy-in programs in one year:

Qualified Medicare Beneficiaries

Clients receive assistance for the costs associated with the Medicare hospital benefit, Part A, and physician services, Part B, including premiums, deductibles and co-payments. These clients may have income as high as 100 percent of the federal poverty level. This program provides a medical benefit and premium assistance for 60,000 individuals; most of these beneficiaries receive Part A for free. However, the department also pays the Medicare Part A premium in the amount of \$461 per month for more than 3,000 clients who do not have enough of their own or a family member's work history to receive free Part A coverage.

Other Medicare savings programs Clients in these programs receive assistance with their Medicare Part B premiums only. Specified Low-income Medicare Beneficiaries (SLMBs) and Qualified Individuals (QI-1s) are those who have income above 100 and up to 135 percent of the federal poverty level. These programs serve more than 25,000 clients with monthly premium assistance of \$99.90.

State Medicare buy-in

We help purchase Medicare Part B for clients eligible for both Medicare and Medicaid (dual-eligibles) who are over income for the Medicare Savings Programs (MSPs). By doing this, the state assures the Medicaid program only pays for medical services, such as physician, radiology and laboratory services

after Medicare has paid as primary payer. APD supports approximately 3,500 clients through this program.

In-home services

In-home services are the cornerstone of Oregon's community-based care system. For aging or people with physical disabilities, the ability to live in their own homes is compromised by the need for support in regular daily living activities. For more than 25 years, Oregon has created options to meet people's needs in their own homes. All options are funded with support of the Medicaid program through home and community-based waivers. Oregon has been able to create cost-effective programs that meet people's needs in their homes and other community settings using these waivers and spared Oregonians from the unnecessary use of much higher cost services, primarily offered in nursing facilities.

Services to aging and people with physical disabilities are designed to support assistance with fundamental activities of daily living (ADLs), such as mobility, cognition, eating, personal hygiene, dressing, toileting and bathing. In order to receive in-home services, an individual must be financially eligible for Medicaid. A case manager works with the client and together they identify needs and develop a plan for the in-home services.

Medicaid client-employed Home Care Workers

Home Care Workers (HCW) are hired directly by the client and provide many of the services Medicaid clients need to remain in their own homes. The client, or his or her selected representative, is responsible for performing the duties of an employer. These duties include selecting, hiring and providing on-site direction in the performance of the care provider duties

authorized by a case manager to meet the client's individual needs and circumstances. The HCW must pass a criminal record check. In conjunction with the client, APD develops and authorizes a service plan, makes payment to the HCW on behalf of the client and provides ongoing contact with the client to ensure his or her service needs are met. Approximately 10,500 clients are expected to receive services supplied by HCWs each month in 2013-15.

The Oregon Home Care Commission (HCC) was established in 2000 by an amendment to the Oregon Constitution. It is a public commission dedicated to ensuring high-quality home care services to APD clients using client-employed providers. Service Employees International Union Local 503, Oregon Public Employees Union represents approximately 15,000 HCW's. For purposes of collective bargaining, HCC serves as the home care worker employer of record. The Commission maintains a statewide, computerized registry of workers and provides an extensive training curriculum. The HCC also makes training available to clients to better understand their employer responsibilities and increase their skill in managing the use of HCWs.

In-home agency services

Many clients prefer to receive their in-home services through a home care agency. These 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. Agencies work closely with DHS case managers and clients to ensure services are provided as authorized and to ensure the quality of the work performed.

Medicaid Independent Choices

This program offers a choice to clients in the way they receive in-home services and increases clients' self-direction and independence. Clients receive a cash benefit based on their assessed need. They purchase and directly pay for services. Clients are responsible for locating providers, paying their employees, and withholding and paying necessary taxes. Depending upon how they are able to manage their service benefit, many are able to purchase a few additional services or items otherwise not covered by Medicaid to increase their independence or well-being.

Medicaid adult day services

These services provide supervision and care for clients with functional or cognitive impairments. Service may be provided for half or full days in stand-alone centers, hospitals, senior centers and licensed care facilities.

Medicaid home-delivered meals

Home-delivered meals are provided for to those who are homebound and unable to go to sites, such as senior centers, for meals. These programs generally provide a hot midday meal and, often, frozen meals for days of the week beyond the provider's delivery schedule.

Medicaid personal care 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.

Medicaid specialized living services

Services are provided to a special-need client base, such as those with traumatic brain injuries or other specific disabilities that require a live-in attendant or other 24-hour care. The services are provided through a contract with APD and targeted to a specific group of clients living in their own apartments, and assisted by a specialized program offering direct service and structured supports.

Oregon Project Independence (OPI)

This is a state-funded program offering in-home services and related supports to individuals 60 years of age and older or people who have been diagnosed with Alzheimer's or a related dementia disorder. Approximately 2,000 Oregonians are served in this program. It represents a critical element in Oregon's strategy to prevent or delay individuals from leaving their own homes to receive services in more expensive facility-based settings, or depleting their personal assets sooner than necessary and accessing more expensive Medicaid health and long-term service benefits. The program was expanded by the 2005 Oregon Legislature to include younger adults with disabilities but no additional funding has been allocated.

OPI is administered statewide by local Area Agencies on Aging (AAAs). Many areas have waiting lists due to high demand and limited program funding. Client eligibility is determined by an assessment of functional ability and natural supports related to activities of daily living. Typical services include assistance with housekeeping, bathing, grooming, health care tasks, meal preparation, caregiver respite, chore services, adult day services and transportation.

The OPI program has no financial asset limitations for clients. A sliding fee scale is applied to clients with net monthly income between 100 and 200 percent of the federal poverty level (FPL) to pay toward the cost of service. A small group with income above 200 percent of FPL pays the full rate for services provided. Generally this is because they benefit from the case management; ongoing support and monitoring, in addition to the actual purchased services.

Community-based care

Community-based facilities

These include a variety of 24-hour care settings and services to provide an alternative to nursing facilities. Services include assistance with activities of daily living, medication oversight and social activities. Services can include nursing and behavioral supports to meet complex needs. State and federal guidelines related to health and safety of these facilities have to be met.

Adult foster homes

Services are provided in home-like settings licensed for five or fewer individuals who are not related to the foster home provider. Homes may specialize in certain services, such as serving ventilator-dependent residents.

Residential care facilities

Licensed 24-hour service settings serve six or more residents and facilities range in size from six to more than 100 beds. Different types of residential care include 24-hour residential care for adults and specialty memory care facilities. Registered nurse consultation services are required by regulation.

Enhanced care services

Specialized 24-hour programs in licensed care settings that provide intensive behavioral supports for seniors and people with physical disabilities who have needs that cannot be met in any other setting. These programs support clients with combined funding from APD and the Addictions and Mental Health division of the Oregon Health Authority (AMH).

Assisted living facilities

These facilities are licensed 24-hour settings for six or more residents including private apartments. Services are comparable to residential care facilities. Registered nurse consultation services are required by regulation.

Providence Elder Place

This is a capped Medicare/Medicaid Program of All-inclusive Care for the Elderly (PACE) providing an integrated program for medical and long-term services. 950 Oregonians age 55 and older are served in this program generally allowing them to attend adult day services and live in a variety of settings. The Elder Place program is responsible for providing and coordinating their clients' full health and long-term service needs in all of these settings.

Capacity

Medicaid residents compete with the private pay market for access to community-based care. The 2008 Supplemental Legislative Session funded an interim rate increase of \$260 per month to help improve access for these clients. Medicaid occupancy levels began to rise and many providers who planned withdrawal from the Medicaid program chose to remain participants. Medicaid access to community-based care is currently strong. When economic conditions strengthen,

APD may lose access as competition with the private pay market for vacant beds will increase.

Acuity-based rate restructure

APD overhauled its community-based care reimbursement system in 2002. The system is outdated in that, although adult foster homes, residential care facilities and assisted living facilities all provide similar services, the reimbursement rate is determined by the setting in which the Medicaid client resides rather than the individual's service needs. In addition, with each passing year, Medicaid rates increasingly fall behind private pay rates. This is especially apparent in Alzheimer's care in the community. The growth of the 85+ age cohort points to increasing demand for Alzheimer's services in both the public and private markets. Increased demand, coupled with static Medicaid payment rates, will also challenge Medicaid client access to specialized services. This was recognized by the Legislature in 2008 and led to the passage of SB 1061, which directed SPD to create:

“A reimbursement structure that ensures access to services while controlling costs and maintaining quality care by:

- (A) Reexamining client acuity and appropriate service priority level designations;
- (B) Developing reimbursement rates that are reasonably competitive with rates paid by private payers;
- (C) Creating incentives for providers to participate in the state medical assistance program; and
- (D) Addressing geographic differentials.”

SPD took a variety of steps to meet this directive, including a private market rate study, stakeholder work groups and a complete rewrite of the rate methodology. These

recommendations are outlined in SPD's Recommendations for Revitalizing Oregon's Community-based Care Reimbursement System document. These reimbursement changes were put forward in the 2009 Legislative Session as a policy option package (POP) and were not funded due to budget constraints.

Nursing facilities

Institutional services for aging and people with physical disabilities are provided in nursing facilities licensed and regulated by DHS. Nursing facilities provide individuals with skilled nursing services, housing, related services and ongoing assistance with activities of daily living.

Oregon has led the nation since 1981 in the development of lower-cost alternatives to institutional (nursing facility) care. Home and community-based alternatives to nursing facility services emphasize independence, dignity and choice and offer needed services and supports at lower costs than medical models.

Program Design

Staff and services support the administration of APD programs, including:

- Central leadership and administration
- Medicaid eligibility and federal waiver administration
- Development and maintenance of administrative rules
- Administration of Medicare Modernization Act and Buy-in programs
- Provider payments and relations
- Support and leadership for various advisory councils.
- Administration of the Older Americans Act
- Home Care Commission

Program Delivery

Staff and services provide direct services to Oregonians, including:

- Direct service staff located in local offices throughout the state
- Presumptive Medicaid Disability Determination Team
- State Family/ Pre-SSI
- Disability Determination Services

Eligibility and case management services are delivered throughout the state by DHS and AAA employees. ORS Chapter 410 allows AAAs to determine which populations they wish to serve and which programs they wish to administer. Type B Transfer AAAs choose to provide Medicaid services in addition to Older Americans Act and OPI services. In areas where the AAAs do not provide Medicaid services, DHS has offices to serve seniors and people with physical disabilities.

HISTORY

Over the past 30 years there has been a profound shift in society's understanding of the importance of independence for aging and people with physical disabilities. Traditionally, states had provided services to these individuals in institutional settings such as nursing facilities. Oregon's first nursing facility opened in the 1940s. With the passage of the federal statute creating Medicaid, the state began to pay for nursing facility services for eligible individuals in the 1960s.

Professional standards and public thinking about how to best serve people with disabilities began to change and life in their communities became more accessible. Civil rights were strengthened and expanded by the Americans with

Disabilities Act, which recently celebrated its 20th anniversary in the areas of employment, public accommodations, transportation and housing. Society became available to individuals with disabilities as accessibility increased and society began to accept people with disabilities as part of the community. Families had the ability to remain intact and to keep their loved ones — child, adult or senior — at home.

Federal dollars to fund Medicaid waivers first became available in 1981 for "Home and Community-Based Services." That same year the Oregon Legislature updated its policies around disabilities and found that significant numbers of people with disabilities lived in institutions because adequate community services did not exist. The Legislature mandated that the state work to empower people with disabilities, keep them as independent as possible, and develop service settings that were alternatives to institutionalization. The 1981 Oregon Legislature also created the Senior Services Division and a strong statutory mandate to support seniors in their own homes and community settings outside of institutions. This action forged the way for Oregon to lead the nation in the development of lower-cost alternatives to institutional care.

In response to that mandate, Oregon applied for, and received, the first home and community-based waiver that allowed Medicaid funds to provide long-term services outside an institution. Throughout the 1980s and 1990s, Oregon received waivers that allowed services for unique groups of people. For Medicaid-eligible aging and people with disabilities in Oregon, this has meant that the provision of long-term care has, in large measure, shifted away from nursing facilities to in-home

services, assisted living facilities, residential care facilities and adult foster homes.

Future populations

The aging population is growing rapidly. The number of people in the United States over age 65 is projected to nearly double from 40.2 million in 2010 to more than 71.4 million people by 2030. In 2010, approximately 13 percent of Oregon's population was 65 years or older. By 2030, the percentage is expected to increase to nearly 20 percent. In Oregon, people 85 years or older make up a small but rapidly growing group within the total population. By the end of 2010, approximately 76,000 Oregonians will have reached age 85. By 2030, the number is expected to reach nearly 120,000, an increase of almost 57 percent.