

Oregon Department of Human Services

Aging and People with Disabilities Programs

Overview

The state of Oregon is a leader in long term care systems. We are ranked number three nationally by AARP. In 1981 Oregon received the first waiver nationwide for long term care services allowing Oregonians receiving Medicaid to choose services in their own home or their communities rather than an institutional facility such as a nursing home. This waiver provides significant benefits to the State in cost savings and allows Oregonians individual choices to best serve their needs. In Home services average approximately 22 percent of the cost of nursing facility services and community based services average approximately percent. Oregonians value receiving long term care services in a non-institutional setting with over 84 percent choosing alternatives that allow them to remain independent and safe.

Long Term Care Setting (as of April 2012)	# of Recipients	% of LTC Caseload
Nursing Facility	4,476	16%
In Home	10,842	39%
Community Based Setting	12,548	45%
Total	27,866	100%

Oregon's population is aging

Our 65+ population is projected to grow from 502,000 to 950,000 by 2030. While we prepare for this growth we know we must do more than create cost effectiveness in the choices of long term care. We must also look at preventative measures Oregonians can implement now so they never need publicly-funded long term care services.

We have prepared a strategic budget with accompanying legislative concepts to focus on modernization and improvements to help Oregonians sustain long term care services. This complex initiative, called Long Term Care 3.0 seeks to achieve the following outcomes:

- Advance a statewide Aging and Disability Resource Connection infrastructure that will help Oregonians make better choices when long term care services are needed.
- Focus on preventative services that delay or eliminate costly long term care services.
- Integrate long term care coordination with Oregon Health Authority's coordinated care organizations.
- Increase home and community based services.

Funding

The cost to operate the Aging and People with Disabilities program is projected to be \$946M general funds for the 13-15 biennium based on current law, however, the Agency Request Budget is \$895M general funds.

	Aging and People with Disabilities Program (APD) - Healthy People Total					
	GF	OF	FF	TF	Positions	FTE
LAB	739,913,132	136,063,227	1,410,741,847	2,286,718,206	1,262	1,251.37
ARB pre Medicare a/b move	894,922,643	158,655,672	1,812,680,806	2,866,259,121	1,330	1,312.47
ARB after Medicare move	768,954,111	158,655,672	1,590,897,403	2,518,507,186	1,330	1,312.47
Difference without move	155,009,511	22,592,445	401,938,959	579,540,915	68	61.10
Percent Change from LAB	20.9%	16.6%	28.5%	25.3%	5.4%	4.9%

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We believe there are general funds that could be saved and reinvested through the following reductions:

- Elect the State Medicaid Plan K option, providing an extra 6% in federal matching funds for most home and community based services.
- Reauthorize the nursing facility provider tax with a comprehensive nursing facility capacity reduction initiative.
- Reinvigorate a strong diversion/ transition initiative that will decrease the nursing facility caseload.
- Increase funding opportunities afforded under the federal Money Follows the Person grant.

Collectively, these reductions amount to nearly \$103M in savings over the biennium and provide opportunities for strategic reinvestment in the Long Term Care 3.0 initiative.

Aging and Physically Disabled Investments/Reductions	APD Program - Healthy People Total					
	GF	OF	FF	TF	Positions	FTE
Reinstate Nursing Facility Rates and Provider Tax	(18.72)	53.59	58.08	92.94		
Decrease Nursing Facility Caseloads through Diversion/Transition Initiatives	(19.04)	(1.83)	(35.59)	(56.46)		
Elect State K Plan option to add 6% match for In-Home programs	(29.17)	0.00	29.17	0.00		
Elect State K Plan option to add 6% match for Community Facilities	(33.98)	0.00	33.98	0.00		
Reinstate Money Follows the Person grant	(0.77)	0.00	0.77	0.00		
Staff eligibility workers at 85% and APS at 95% of workload model	2.52	0.00	2.50	5.02	32	32.00
Add capacity to meet mental health needs and reduce # served at OSH	13.64	0.00	10.79	24.44	8	6.72
Increased capacity for Care Coordination and Statewide ADRC Development	3.03	0.00	7.88	10.91	9	7.92
Add capacity for high needs clients to transition out of Nursing Facilities	1.98	0.00	3.30	5.29		
Streamline processes with an online electronic data mgt system for HCW	0.09	0.00	0.08	0.17	1	0.88
Create APD Innovation Fund to test ideas to lower cost and increase quality	9.00	0.00	0.00	9.00		
Add Case Management/OPI services for individuals not Medicaid eligible	4.64	0.00	1.24	5.88	7	5.02
LTC 3.0 infrastructure funds to move to a modern case management system	10.00	0.00	10.00	20.00	9	7.92
Increase Home and Community-Based Care rates after 5 years of flat rates	16.00	0.00	35.00	51.00		
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	(125.97)	0.00	(221.78)	(347.75)		

LTC 3.0 Strategic Funding Investments

Mental health capacity: Increase capacity to meet the needs of aging or people with disabilities who have mental illness. APD currently serves those with severe and persistent mental illness in specialized nursing facilities and residential care facilities and all are at capacity and have waiting lists.

This proposal includes four major components:

- Increase 40 specialized living slots supporting both APD and the Oregon Health Authority Addictions and Mental Health program by significantly decreasing the number of seniors served in the Oregon State Hospital. A significant percentage of aging residents we serve at the Oregon State Hospital suffer from traumatic brain injuries, dementia or other organic brain syndromes and placement in an institution for mental disease is not appropriate or cost effective.
- Coordinate mental health evidenced based interventions through ADRC's such as "IMPACT," "PEARLS," and other programs that are recommended by the CDC or SAMHSA for aging and people with disabilities who may be suffering from depression, anxiety and other less severe mental

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illnesses. This does not duplicate current mental health services nor does it substitute services local CCOs are expected to provide.

- c. Training and support programs for case managers, direct care providers, health professionals and others on mental health screening to ensure that older adults and people with disabilities receive the appropriate screenings and interventions.
- d. Develop a statewide Gatekeeper program to enlist the help of utility workers, law enforcement, postal workers, and other service providers to help identify people in need of support. Currently, Gatekeeper programs are only available in Multnomah, Washington, and Clackamas counties. These programs have a long standing evidenced based record of positive impact.

Special population capacity: Support special population capacity development, allowing more individuals to be served outside of nursing facilities at lower costs. Some of the service gaps include settings serving individuals who are obese, or ventilator- dependent or have traumatic brain injuries.

Care Coordination: Invest in high quality care coordination services for Medicaid and non-Medicaid individuals to assist with better health, better care and lower costs and to help prevent some individuals from needing Medicaid-funded LTC in the first place. Case managers are only staffed at a level to provide generic, priority-based case management to individuals with Medicaid-funded Long Term Service and Support (LTSS). This investment would support staff to direct the work of care coordination between offices and Coordinated Care Organizations (CCOs) and increase the number of options counselors to serve individuals with LTSS needs who are not Medicaid eligible.

Case Management: Pilot a case management approach focused on risk intervention to individuals not currently served in Medicaid-funded long term care services. We currently serve over 140,000 Oregonians, but case management services are only offered for the Medicaid-funded long term care service subset, or approximately 28,000 individuals. We would work in concert with the CCO's to improve the triple aim of better health, better care and lower costs for this population. We also seek to fund Oregon Project Independence services for adults with disabilities in order to comply with Oregon statute.

Innovations: Test ideas to increase quality and lower costs through an "innovation fund". Potential initiatives include improved coordination with CCOs, piloting new service delivery methods and testing new technology. These initiatives will be tracked and the outcomes measured allowing new evidence-based approaches to increase the efficiency and effectiveness of services.

Technology: Leverage the DHS Oracle investment with further technology infrastructure investments to implement a scalable assessment, service planning and case management system to save time, resources, and minimize risk. Other DHS programs will benefit from this initiative.

Provider Rates: Increase rates for home and community based providers. A modest increase will assure continued strong access to home and community based services as we compete in the private market. By the end of the 2011-2013 biennium, these provider groups will have had flat rates for five years (July 2008).

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Streamline operations: Provide an on-line Home Care Worker application and subsequent on-line training and provider file documentation to improve resources and streamline process for applicants. The online application will interface with CRIMS on initial criminal background checks. This will reduce data entry and provide a central electronic location for provider files, reducing paper storage and allow files to be accessed through the service delivery system across the state, the Home Care Commission and the Office of Financial Services.

Staffing: Add eligibility and adult protective services staff to meet the needs and expectations of Oregonians for the safety and protection of those we serve. We have transitioned staffing requests from a caseload ratio model (e.g. 1 case manager for every 60 cases) to a workload model that more accurately reflects the workload of local offices. This initiative seeks to fund eligibility workers who assess the necessary services to 85% of the workload model and staff those workers who provide protective services keeping individuals safe to 95% of the workload model.

Conclusion

These initiatives, collectively called LTC 3.0, will help Oregon ensure its long term care system is sustainable and ready to address the inevitable aging population. We believe these initiatives support preventative services to keep individuals from needing long term care in the first place and help all consumers receive high quality, unbiased information on long term care choices as it becomes necessary. Our path to transforming long term care honors choice, safety and independence and offers the most cost-effective solutions allowing our aging population to thrive and approach aging with confidence and dignity. We believe these initiatives will help the state best manage the resources available by providing the right services are delivered at the right time and place through efficient and effective staff to meet the changing population of Oregonians.