Oregon

John A. Kitzhaber, MD, Governor

Department of Human Services

Office of the Director

500 Summer St. NE, E-62

Salem, OR 97301

Voice: 503-945-5600

Fax: 503-581-6198

March 29, 2013

The Honorable Alan Bates, Co-Chair
The Honorable Nancy Nathanson, Co-Chair
Ways and Means Subcommittee on Human Services
900 Court Street NE
Salem, OR 97301

Dear Co-Chairs:

This is in response to the committee's questions during Day Two of the Aging and People with Disabilities (APD) Presentation on March 26, 2013.

Question: The Committee asked for additional information about Money Follows the Person and Oregon's intent to reopen the program

Answer: See Response Below

Introduction

The Department of Human Services (DHS), Aging and People with Disabilities (APD) has historically had grant responsibility for the Money Follows the Person (MFP) Program, branded previously as "On the Move in Oregon." In October 2011, Oregon suspended providing direct services to clients through On the Move, per amendment 5 of the grant. The purpose of the suspension was to give DHS the needed time to complete a thorough review of the program. In 2012, a decision was made in conjunction with our Addictions and Mental Health (AMH) partners in the Oregon Health Authority to pursue reopening the program and expanding the populations served to include APD, AMH, and most recently those with Developmental and Intellectual Disabilities.

This Legislative report outlines continuation of the MFP program which seeks to promote community-based options and support state efforts to reduce institutionalized care. An enhanced Federal Match rate of 81 percent is available for those receiving services under this program. Individuals are potentially eligible

to receive services under MFP when moved to a qualifying residence after 90 days in an institution. Funding is available under the enhanced match rate for up to a year after moving to the community setting. As a condition of the grant, savings from the program are reinvested to enhance a state's community based care system. Services after the MFP year revert to the normal Federal Match rate.

Timelines/ Milestones

- Reconstituted Stakeholder meeting July 2012
- Project Director/Deputy Director on board January 2013
- Regular stakeholder meetings beginning April 2013
- Revised protocol submitted April/May 2013
- Potential Services start date July 2013

New Design – Oregon Community Choices Program

Oregon maintains the MFP program under a reinvented strategy that includes a joint partnership between APD, Addictions and Mental Health (AMH), and the Office of Developmental Disabilities Services (ODDS), expanding the scope of the program to cover populations served by the three programs. APD continues to administer the program in its Advocacy and Development Unit, with a governance structure that includes a steering committee of equal membership from APD, AMH and ODDS. To recognize the commitment to program integrity, efficiency of operations, increased transparency, and meaningful stakeholder involvement the program is rebranded as the Oregon Community Choices Program.

Phased-In Approach

DHS and OHA will be using a phased-in approach to build the program at a speed that is manageable.

Phase 1 (July 1, 2013-June 30, 2014) will consist of identifying populations in APD, AMH and ODDS who meet the service eligibility definitions for MFP and building administrative safeguards and a coding infrastructure for reporting and capturing enhanced match and savings for reinvestment. In phase 1, only the current Medicaid in-home services will qualify. Discussions with APD, AMH and ODDS indicate initial populations exist that could be served under this proposal and timeline.

Phase 2 (2014) may potentially expand the program to include other services, settings or populations based on Stakeholder and steering committee

recommendations. These settings would include congregate settings of no more than four or fewer unrelated residents.
Phase 3 (2015) Final expansion of populations, services and settings would occur again based on stakeholder and steering committee recommendations.
Phase 4 (2016) Program fully functioning and assessed for moving out of Advocacy and Development Unit and into appropriate APD unit.

Stakeholder Involvement

On July 31, 2012, APD reconvened the stakeholder group originally created under the previous MFP program. Stakeholders include providers, consumers, and advocates for seniors and people with disabilities. Stakeholders indicated strong support for reconstituting MFP, and broadly agreed with the phased-in approach outlined above. They also advocated for robust stakeholder advisory participation, greater transparency and reporting structure and measurable outcomes with which MFP is to be evaluated. Finally, stakeholders agreed that any person served by MFP should have a truly person-centered plan for them to successfully make the transition from an institution into a home or community based setting.

Stakeholder volunteers were solicited to interview candidates for the Director positions. Four volunteer stakeholders (two consumer advocates, Oregon Health Care Association, and O4AD) assisted with the selection process.

The department will meet regularly with this stakeholder group during the grant period. Now that the MFP Directors are staffed in APD, the next stakeholder meeting is scheduled for April 3, 2013.

Monitoring and Quality of Life Survey

Additional workload is required for those moved under the MFP program including specific monitoring requirements and a Quality of Life Survey. To reduce field workload impact, and provide objective reporting the Quality of Life Survey will be contracted.

Question: Please give us information on Continuing Care Retirement Centers (CCRCs) in order to answer questions coming from these facilities

Answer: Impact on Continuing Care Retirement Communities (CCRCs)

There are 16 CCRCs of which 12 directly run nursing facilities. CCRCs cost per resident day varies among the providers ranging from $142 per day to $537 per

day. The current nursing facility provider assessment is $18.35 per resident day. Based on this assessment rate, the average tax rate will be 4.87 percent of NF revenue.

HB 2056

Background

HB 2056 was developed jointly with the majority of the nursing facility industry. Oregon's low occupancy rate (the lowest in the nation) is driving up costs for both private pay and Medicaid residents. Many of the facilities are old and their structure is obsolete. Many are extremely close to other facilities.

The concept behind HB 2056 is to shrink unnecessary capacity by incentivizing nursing facilities to reduce capacity by purchasing and closing unnecessary facilities. Purchasing facilities will receive an augmented rate to offset a portion of the purchase. Selling facilities will keep the building and the land. These sellers will be able to make independent business decisions on the best use of their land and buildings. Some may choose to repurpose their facilities to serve other populations or remodel so they can be licensed as another setting. Others may choose to change to other business opportunities.

It is important to note that essential community providers may not participate in the program. The goal of this prohibition is to ensure access in rural and frontier communities. Additionally, purchasing providers must meet quality standards so that we can ensure that the individuals receiving care in the remaining facility receive the best care possible.

Scenarios

The following scenarios highlight just a few of the situations that are likely to be impacted with the passage of HB 2056. The scenarios are not intended to indicate any specific facility that may purchase or close.

Scenario 1

Facility 1 is licensed at approximately 90 beds and has occupancy percentage of 36.1 percent (approximately 58 beds not being used). This facility was originally opened in 1969. The facility is not exempt from provider assessment and pays the quarterly tax to the state. Facility 2 (114 beds) and Facility 3 (84 beds) are less than 3 miles away from Facility 1. These facilities have an average of 63.3 percent occupancy.

Scenario 2
Facility 1 is licensed at approximately 100 beds and has occupancy percentage of 32.04 percent. This facility was originally licensed in 1973 and is not exempt from provider assessment. Facility 2 (40 beds) is 2.54 miles away and facility 3 (87 beds) is 2.8 miles away, with an average occupancy between the two at 56.5 percent.

Impact on Capacity
Current occupancy rate in Oregon are at 60.9 percent. If the 1,500 bed target set in HB 2056 is realized the projected occupancy percentage will be 70 percent. This means that there will still be over 3,000 available beds in Oregon nursing facilities throughout the state.

Question: Please provide information about the assessment process

Answer: Please see Attachment #1

Question: At what point do you close, what are the standards for closing a case? Are they counted in your workload model?

Answer: Cases are closed once an individual is found no longer financially eligible or no longer meeting criteria for long term care. In general, most cases are reviewed annually. As stated during the hearing, inactive cases are not included in our caseload counts nor are they in the calculation of our staffing levels through the workload model. In our presentation on March 25, slide 4 reflected our current APD caseloads. These numbers are for active cases only. We do not have numbers of inactive cases, as we close them and do not maintain them as a part of worker caseloads.

Thank you,

Sincerely,

Eric Luther Moore
Chief Financial Officer
503-884-4701

eric.l.moore@state.or.us

ELM/cw

cc: Laurie Byerly

Attachment #1:

Nursing Facility Provider Assessment
Aging and People with Disabilities
Department of Human Services

Nursing Facility Provider Assessment
Aging and People with Disabilities
Department of Human Services

State Law

Under Oregon law, the Department of Human Services administers, enforces, and collects the provider taxes. The Department of Human Services operates the provider tax program under Oregon Administrative Rules (OARs) 411-069-0000 through 411-069-0170.

Oregon Nursing Facility Tax Rate

The long term care facility tax rate is an assessment rate times the number of resident (bed) days at a long term care facility. Oregon (and Federal) law permits the department to collect up to 6 percent of annual gross resident service revenue. Provider tax dollars are used to fund Basic and Complex LTC services. At present, the Department collects approx. $10M per quarter in Other Funds.

Sunset Provisions in Oregon Law

The current long term care facility tax sunsets effective July 1, 2014. HB 2056 would change the sunset date to June 30, 2020.

Benefit of Provider Taxes

The provider taxes established in Oregon are industry supported. With the implementation of provider taxes, provider payments were increased, bringing increased financial stability to nursing facilities. In addition the provider taxes allow Oregon to draw additional federal funds further adding to system resources.

Assessment

All nursing facilities in Oregon are subject to the long term care facility tax except the Oregon Veterans' Home and nursing facilities that have received written notice from the Department that they are exempt under the terms of a waiver.

Currently, Continuing Care Retirement Communities (CCRCs) and nursing facilities with greater than 85 percent Medicaid occupancy qualify for the exemption. HB 2056 will remove the exempt status for these groups.

The tax is assessed to a nursing facility 30 days following the end of each calendar quarter. The amount of the tax equals the assessment rate times the number of resident days, including Medicaid resident days, at the long term care facility for the calendar quarter. The target of the quarterly assessment is to collect a statewide aggregate 6 percent of resident service revenue for the fiscal year.

The Department determines the assessment rate annually by dividing the projected revenue by the projected resident days for the fiscal year. The Department also reconciles collections at the end of each year as the 6 percent cannot be exceeded.

Cash Flow

Because this tax is collected quarterly, the Department essentially collects each quarters funding after it has been spent. This means the department fronts GF until the tax is received. While Department manages its cash flow on a daily basis, at the end of the biennium this requires a line of credit from Treasury to deal with cash slow issues.

Revenue history

The Department of Human Services collected the following revenue from Long Term Care provider tax to fund Basic and Complex LTC services:

2004 Long Term Care Tax:	$24.2 million
2005 Long Term Care Tax:	$29.2 million
2006 Long Term Care Tax:	$32.7 million
2007 Long Term Care Tax:	$35.2 million
2008 Long Term Care Tax:	$37.8 million
2009 Long Term Care Tax:	$37.0 million
2010 Long Term Care Tax:	$36.6 million
2011 Long Term Care Tax:	$37.7 million
2012 Long Term Care Tax:	$40.1 million
2013 Long Term Care Tax:	$42.1 million (projected)

The revenue was matched with federal Medicaid. The combined total funds were used to reimburse nursing facilities for the care provided to Medicaid recipients.