Oregon
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January 13, 2012

The Honorable Senate President Peter Courtney
The Honorable Co-Speaker of the House Bruce Hanna
The Honorable Co-Speaker of the House Arnie Roblan
900 Court Street, NE
Salem, OR 97301

RE: Report for the House Bill 5030 (2011) Budget Note on Oregon's Long Term Care System

Dear Legislators:

House Bill 5030 (2011) directed the Governor to convene key stakeholders and Department of Human Services (DHS) staff to make recommendations in January 2012, preserving and enhancing Oregon's long term care system for seniors and individuals with disabilities.

The enclosed report is the result of two stakeholder workgroups convened by the Governor. The report is also posted on the DHS website at: http://www.oregon.gov/DHS/aboutdhs/budget/2011-2013/index.shtml

Sincerely,

Eric Luther Moore
Chief Financial Officer

Enclosure

cc: The Honorable Senator Alan C. Bates
The Honorable Representative Jean Cowan
The Honorable Representative Tim Freeman
The Honorable Representative Vic Gilliam
The Honorable Representative Carolyn Tomei
The Honorable Senator Laurie Monnes Anderson
The Honorable Senator Jeff Kruse

George Naughton
Ken Rocco
Gina Rumbaugh
Sheila Baker
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Report for the House Bill 5030 (2011) Budget Note on Oregon's Long Term Care System

January 2012

Executive Summary

House Bill 5030 (2011) directed the Governor to convene key stakeholders and Department of Human Services (DHS) staff to make recommendations preserving and enhancing Oregon's long term care system for seniors and individuals with disabilities.

The Governor assigned two groups to work on specific subsections of this budget note. Representatives of the Oregon Disabilities Commission, Governor's Commission on Senior Services, State Independent Living Council and Area Agencies on Aging focused on the best mix of services and supports to prevent or delay Medicaid eligibility. A subgroup of the Governor-appointed Medicare-Medicaid Integration of Care and Services Workgroup focused on the best blend of resources, alignment, and cost efficiencies and incentives for services to individuals with triple eligibility: Medicare, Medicaid, and Medicaid-funded long term services and supports. Much of the work of the second group focused on the relationship between the long term care system and the changes to health care delivery through the development of Coordinated Care Organizations (CCOs).

Common themes emerged among the recommendations of each group. Themes include directing more resources to preventative, low cost, and least intrusive services and supports, better communication and coordination among service providers, and education and empowerment of individuals receiving services and supports.

<u>Recommendations for the best mix of services and supports for individuals at high risk of Medicaid eligibility:</u>

- Strengthen and enhance the Aging and Disability Resource Connection (ADRC) as the organizational structure to provide information, referral, preventative and support services to individuals statewide;
- Recognize OPI as only part of a larger prevention and early intervention continuum. Strengthen OPI through a more rigorous assessment of the program and expand on the supports for individuals and caregivers before they qualify for more costly Medicaid Long Term Care programs;
- Mitigate health and behavioral risks of Medicaid eligibility through health promotion and preventative programs, transition programs, employment programs, and community health improvement assessment programs;

- Mitigate social and environmental risks of Medicaid eligibility through volunteer and peer mentoring programs, family caregiver programs, and housing and employment programs; and
- Mitigate financial risks of Medicaid eligibility through strengthened awareness and training to prevent financial fraud, abuse and exploitation, promotion of long term care insurance and other money management programs.

Recommendations for the best blend of resources, alignment, and cost efficiencies and incentives of services for individuals who are eligible for Medicare, Medicaid, and Medicaid long term services and supports:

- Pursue flexibility of resources (such as purchasing Durable Medical Equipment) to maximize appropriate, lower cost services and supports and opportunities to use private contributions for federal match;
- Pursue promising models of service and care coordination (e.g., Co-Location, Services in Congregate Settings, Clinician/Home-Based Programs) for better alignment of services provided by CCOs and the long term care system;
- Enhance service coordination between the long term care system and CCOs through memoranda of understanding, robust information sharing and coordination with interdisciplinary teams, transition planning, reduced duplicative practices, and education and engagement of individuals receiving the service; and
- Reduce the risk of cost shifts between CCOs and the long term care system through shared accountability mechanisms, such as appropriate outcome and process metrics, financial incentives and shared savings for coordination of services, and possibly penalties where appropriate (e.g., not paying for duplicative services when providers do not follow the service plan).

DHS is actively looking for ways to realign existing resources and system supports with the recommended actions. Generally speaking, however, both workgroups agreed that some additional, upfront investment in these strategies would yield a return on that investment, i.e., better outcomes for individuals and their caregivers, and more cost-effective use of federal, state and local resources.

DHS and its external stakeholders look forward to further direction from the Legislature regarding its priorities for next steps.

Subsection (1) Group:

- Ann Balzell, Oregon Disabilities Commission (ODC)
- Jonathan Bartholomew, Governor's Commission on Senior Services (GCSS)
- Peggie Beck, GCSS
- Brenda Durbin, Area Agencies on Aging and Disabilities (O4AD)
- Ryan Green, ODC
- Ruth A. McEwen, ODC
- Barry Fox-Quamme, State Independent Living Council (SILC)
- Charles Richards, GCSS
- Rodney Schroeder, O4AD
- Catherine Skiens, GCSS
- Sherry Stock, ODC
- Sheila Thomas, SILC
- Tina M. Treasure, ODC
- Kenneth Viegas, GCSS

Staff:

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- Bill Lynch, Meeting Outcomes (Facilitator)
- Patricia Baxter, Aging and Physical Disabilities Chief Operating Officer
- Elaine Young, State Unit on Aging
- Linda Dreyer, State Unit on Aging
- Lori Watt, State Unit on Aging
- Kelsi Eisele, DHS
- Max Brown, DHS

Subsection (2) Group:

- Rhonda Busek, BS, MBA, PacificSource Health Plans
- Jim Carlson, Oregon Health Care Association
- Ellen Garcia, MPH, Providence ElderPlace
- Ruth Gulyas, Oregon Alliance of Senior and Health Services
- Jennifer Hahn, GNP-BC, Peace Health Medical Group
- Mary Rita Hurley, RN, MPA, Oregon Center of Nursing
- David Komeiji, BA, PT, MMSC, Retired
- Kay Metzger, Lane Council of Governments Senior and Disability Services
- Veronica Sheffield, MS, BS, BSN, RN, Willamette Valley Providers Health Authority

Staff:

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- Susan Otter, Office of Health Policy and Research (OHPR) (Co-Chair)
- Selina Hickman, APD Services
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- Kate Sharaf, OHPR
- Bob Weir, OHPR
- Matt Bartolotti, OHPR
- Kelsi Eisele, DHS
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Introduction

House Bill 5030 (2011) directed the Governor to convene key stakeholders, including representatives from the Department of Human Services (DHS), to develop recommendations for enhancing and preserving Oregon's long term care (LTC) system[1] for seniors and individuals with disabilities. This budget note requested recommendations regarding:

(1) The best mix of services and supports, including supports to caregivers, to be available in every Oregon community that will keep seniors and people with disabilities as independent as possible, healthy and safe.

(2) Specific plans and recommended steps to best blend state and federal resources with private pay to assure access to high quality care and supports for individuals, families and caregivers.

(3) Plans and recommended steps to better align state and local administrative structures, identify cost efficiencies and create incentives to assure consistent, efficient and effective service delivery and high quality service outcomes.

In convening key stakeholders and DHS representatives, the Governor tasked two groups to work on the budget note subsections by taking them in specific directions. For subsection (1), the Governor asked the group to focus on "non-Medicaid" programs and systems design that prevent or delay entry into Medicaid programs, while supporting the financial independence of seniors and individuals with disabilities as long as possible. For subsections (2) and (3), the Governor asked a separate group to focus on individuals with "triple eligibility": seniors and individuals with disabilities who receive Medicare, Medicaid and Medicaid-funded long term services and supports (LTSS).

The group working on subsection (1) included five representatives from the Oregon Disabilities Commission (ODC), five representatives from the Governor's Commission on Senior Services (GCSS), two representatives from the State Independent Living Council (SILC), and two representatives from the Area Agencies on Aging (AAA). The group working on subsections (2) and (3) was

[1] For purposes of this report, "long term care" (LTC) refers to the system of long term services and supports, including nursing facilities, community based care, and in-home services. "Long term services and supports" (LTSS) refers specifically to these services.

convened as a subgroup of the Governor-appointed Medicare-Medicaid Integration of Care and Services Workgroup.

The need to plan for the future of LTC in Oregon is compelling. One reason is that over the next twenty years, Oregon's aging demographic will change significantly. In 2009, slightly more than one in every eight people was age 65 or older; by 2030, nearly one in five will be 65 or older. Additionally, there will be a significant increase in individuals 85 or older. In 2010, about 76,000 reached age 85; by 2030, this group is projected to be over 120,000, an increase of almost 60 percent. In addition to the growing senior population, an increasing population of younger individuals with disabilities constitutes a significant portion – nearly 40 percent – of people receiving long term services and supports.

Oregon's Medicaid program provides LTSS as a safety net for seniors and individuals with disabilities who have exhausted all other resources available to them and meet the Medicaid criteria for assistance with activities of daily living (ADLs). Most individuals with Medicaid LTSS also qualify for Medicare, and are therefore are individuals with "triple eligibility": they receive Medicare, Medicaid, and Medicaid LTSS.

At this time, the future growth of Oregon's Medicaid LTC system is unsustainable. Since the start of the recession in 2008, Oregon's General Fund (which provides the required state match used to draw down federal Medicaid funds) has fallen and, according to most projections, will not keep up with the growing need for Medicaid-funded LTSS over the next decade. The federal government provided a boost to the Medicaid program with an enhanced match under the American Recovery and Reinvestment Act (ARRA) of 2009, but that supplemental funding ended on July 1, 2011. With no other supplemental funding in the offing, Oregon faces both a short and long term budget deficit in the future. Medicaid continues to be the fastest growing expense in state budgets. As such, it is imperative that Medicaid, including the Medicaid LTC system, can continue to provide for those who need it, even under current and future fiscal realities.

In 2011, new state legislation and federal policy changes provides some new opportunities to rethink the future of LTC in Oregon – both Medicaid LTC and beyond. On the state level, the 2011 Legislature passed House Bill 3650, which creates a new form of delivering many Medicaid services through Coordinated Care Organizations (CCOs). Under this legislation, CCOs, once fully implemented, will be responsible to integrate and provide Medicaid-funded physical, behavioral, and oral health services for the individuals enrolled. Entities seeking to become

CCOs will demonstrate that they meet specific criteria and be certified as CCOs by the state, and then will be given global budgets to cover services for Medicaid enrollees in a particular geographic area, while being held accountable to performance measures designed to ensure that quality care is delivered, health outcomes improve, and costs are reduced.

On the federal level, the Centers for Medicare and Medicaid Services (CMS) offered all states the opportunity to pursue three-way contracts among health plans, the state, and CMS for blended Medicare and Medicaid payment to plans, set at a level to target savings that can be shared. This opportunity is available for plans that fully integrate Medicare and Medicaid services, including LTSS in addition to physical and behavioral health services. The Oregon Health Authority is working with DHS to prepare a formal proposal to integrate care for dually eligible beneficiaries under a CMS initiative—called the "design contract." Oregon has submitted a Letter of Intent indicating that it will be including this blended capitation approach in its design contract proposal to CMS. The work under subsections (2) and (3) of this report will support the development efforts of Oregon's proposal to CMS.

HB 3650 and new policies of CMS create new opportunities for more efficient health care delivery and savings for Medicaid, yet HB 3650 explicitly excluded the LTC system from the purview of CCOs. The opportunity for making Medicaid LTC sustainable, then, lies in the possibility that its system can coordinate with the other Medicaid-provided services under the CCOs. This type of coordination and alignment will also be required in order to meet CMS expectations for integration of LTSS in order to bring in the Medicare funding. If LTSS can work in concert with better care coordination of physical, mental, behavior and oral services, then both the CCOs and the Medicaid LTC system may mutually benefit by slowing the growth of costs and serving a growing need with fewer available resources in the future.

But given the sheer gravity of the growing disparity between available revenue and the demographic changes coming to Oregon, it is imperative to devote as much – if not more – thinking to long term services and supports outside Medicaid's LTC system. In this vein, the Governor requested that the group working on subsection (1) make recommendations for the best mix of services and supports to keep seniors and individuals with disabilities as financially independent as possible so as to prevent or delay their entry into Medicaid LTC. What follows is a list of recommendations created and agreed to by the group listed above for subsection (1). This report then provides recommendations from group addressing Medicaid

LTC – subsection (2) and (3) of the budget note, and concludes with next steps for Oregon's system of LTC – both in Medicaid's system and beyond.

Subsection (1): Recommendations on the best mix of services and supports to keep seniors and individuals with disabilities as financially independent as possible so as to prevent or delay their entry into Medicaid LTC.

In meeting Oregon's LTC challenge, much work remains to be done for those who need long term services and supports, but who are not yet eligible for Medicaid LTC. As cited in the department's "A Report on: Long-Term Care in Oregon" (September 2010), national studies indicate that 80 percent of LTSS is provided and paid for by the individual, family members, and friends and close to 30 percent of all households are involved in some kind of caregiving for seniors and individuals with disabilities. This assistance poses challenges for caregivers, often leaving family members and friends overwhelmed. Moreover, most seniors and individuals with disabilities lack the financial resources to afford to pay for private LTSS for more than a few weeks or months.

This picture grows worse by current financial conditions of most households. Personal savings and retirement savings of the cohort over age 50 are insufficient for the long term supports and services they will need as the population becomes older. Private long term care insurance plans usually only cover limited periods for home health care and nursing facility care for those recovering from a serious illness or injury, and only a small percentage of Oregonians hold these insurance policies. Meanwhile, according to 2010 figures, nursing facilities in Eugene cost $85,000 a year, while home care services in Portland, for private pay individuals, costs $22,000 a year if care is provided four hours a day, five days per week.[2] As the aforementioned 2010 report notes:

> When people begin to look for help for themselves, their spouses, an aging parent, or for a person with disabilities, they often do not have the information, skills or supports to make informed decisions. As a result, they often end up using more intense and expensive levels of care than are necessary. This is ironic since, over the course of the last two decades, there has been a dramatic increase in the amount of information, products, and options available to assist older people, people with disabilities, and their families to manage their needs.

[2] MetLife Mature Market Institute, "Market Survey of Long-Term Care Costs," October 2010.

In facing the challenge to future LTSS needs in Oregon, then, the group examining subsection (1) considered many previous recommendations for the "non-Medicaid" population. In so doing, the group found many recommendations to implement, as well as some gaps that began to address shortcomings in previous recommendations.

In making recommendations for the non-Medicaid population, the group came to a consensus on who was at high risk for Medicaid eligibility. One indicator is financial eligibility – a senior or individual with disability that met income eligibility for Medicaid LTC (currently $2,022 a month, or 300 percent of Supplemental Security Income eligibility), and who had under $40,000 in liquid assets (equivalent to six months of the cost for a private-pay stay in a nursing facility). Beyond the basic financial criteria and risks for Medicaid eligibility, the group also considered two other major risk categories for Medicaid eligibility: health and behavioral risks and social and environmental risks.

The recommendations are also informed by certain principles. First, these recommendations are made in the context of changes occurring to Medicaid-covered health and behavioral services under House Bill 3650. This transformation does not always affect the non-Medicaid population directly, but many social systems and supports for the non-Medicaid population can benefit from closer collaboration with the Coordinated Care Organizations (CCOs) established under HB 3650. In so doing, this group believes that this collaboration can create the conditions under which the social model of social services may positively transform the medical model of health and behavioral services, instead of bringing the medical model to social services and supports.

Secondly, in keeping with the principles of individual independence, choice, and dignity, these recommendations reflect a commitment to culturally competent services that empower the individual regardless of his or her race, gender, ethnicity, religion, native language, sexual orientation, or geographic area.

Recommendations begin with a more robust development of Oregon's Aging and Disability Resource Connections (ADRC) program, as well as strengthening its system of long term supports, including Oregon Project Independence, for the non-Medicaid population at risk for Medicaid covered LTC for health and behavioral risks, social and environmental risks, and financial risks.

Aging and Disability Resource Connection (ADRC)

As an organizing and foundational principle, the Aging and Disability Resource Connection (ADRC) is a critical structure to provide public education in addition to the four core services of:

1. Information and Assistance,
2. Options Counseling,
3. Person-Centered Transition Support, and
4. Evidence-Based Health Promotion.

The ADRC provides an organizational structure for coordination and collaboration between the Area Agencies on Aging (AAAs),[3] Centers for Independent Living (CILs)[4] and other key community partners to lessen duplication of services and to assure the most comprehensive information possible is provided in an efficient and effective manner.

Evidence in other states that have developed and implemented ADRCs has shown their benefit to bend the escalating cost curve for long term care and health care downward. A specific example is Wisconsin where they began ADRC implementation in the late 1990s and a recent status report indicates a significant benefit to local economies with more efficient information and access to various programs, a reduction in falls and medical costs through the use/implementation of evidence-based health promotion programs and high marks for consumer satisfaction. Additionally, data compiled by the Lewin Group for a study called "Project 2020" clearly shows the cost benefit, cost offsets and potential cost

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[3] AAAs were established under the Older Americans Act (OAA) in 1973 to respond to the needs of Americans 60 and over in every local community. By providing a range of options that allow older adults to choose the home and community-based services and living arrangements that suit them best, AAAs make it possible for older adults to remain in their homes and communities as long as possible. AAAs leverage federal OAA funds with local community resources to provide support services, including specialized information and assistance, transportation, in-home care; nutrition services through congregate and home-delivered meals; preventative health services through medication and chronic disease self-management; family caregiver supportsl and elder rights protections. AAAs, which are also local government entities, also have the option to deliver services under the Medicaid Home and Community-Based Services waiver for older adults and adults with physical disabilities. AAAs operate in all Oregon counties and are guided by consumer-directed advisory councils.

[4] CILs provide specialized information and resources for people with all types of disabilities and regardless of age, all provided through a system which is governed and operated by people with disabilities themselves. Their expertise comes directly from peers who understand disability and the realities of living with such, as well as utilizing support services. The philosophy of Independent Living at its core, is based on self-sufficiency and self-determination. CILs currently provide general Information/Referral, skills training, peer counseling and advocacy to promote independence in all but 14 counties of the State of Oregon, with specialized, contracted services provided statewide.

avoidance of providing the services and core functions of the ADRC related to nursing facility diversion and preventing/delaying spend-down to Medicaid. The ADRC Advisory Council has also adopted, and will be reporting on, several performance targets related to consumer satisfaction and outcome measures.

Over the last three years with the support of federal grants, Oregon has started ADRC implementation. To date the following has been accomplished:

- Procurement and launch of a public website that supports a searchable resource database.
- Procurement of a contact system that captures consumer information such as demographics, service needs, information/referral provided, need for follow-up. This information produces management and data reports to track ADRC performance.
- Adoption of continuous quality improvement plan and consumer-based standards for Information and Assistance and Options Counseling.
- Contract with Portland State University Institute on Aging to develop and conduct a consumer satisfaction survey of ADRC services that will inform the setting of metric thresholds for the ADRC standards.
- Professional, Supervisor, Service delivery standards developed for Options Counseling.
- Staff training curriculum and train-the-trainer curriculum developed for Options Counseling. (80 staff and 30 supervisors have completed the training to date)
- One statewide brand to facilitate ease of access for consumers.
- Support to AAAs for national certification of Information and Assistance staff (43 staff to date are certified).
- Adoption of a 5-year strategic plan for statewide implementation of the ADRC.

Additionally, Oregon has completed or will soon complete grant-funded projects that have identified promising practices in the areas of care transitions, options counseling, and evidence-based health promotion and caregiver supports. These projects also produced important insights about consumers who have high healthcare utilization, a risk factor for Medicaid spend-down.

Once further developed and implemented, the ADRC will provide more Oregonians the necessary information and resources to make informed decisions, which will enhance people's ability to live as independent, healthy and safe as possible. This is good for the individual, the family and Oregon. People are

happier when they are able to make decisions about their own lives, and this depth of information and resources provided through a collaborative and inclusive process is both efficient (minimize costs) and effective (deliver high quality services to individuals). Unlike other information and referral services (such as 211), ADRCs specialize in targeted information and resources affecting seniors, individuals with disabilities, and their families, friends, neighbors, medical professionals and advocates.

ADRC implementation statewide should be a two part process to maximize our ability to quickly provide information and resources to Oregonians in the near term by utilizing existing structures, resources and recently developed technology; which can be expanded and enhanced as time progresses by broadening collaboration, training and the depth of ability across the state. The group recommends the following:

Recommendations – ADRC

- Phase I: By December 31, 2012 all areas of the state will be covered by a virtual ADRC which will provide all Oregonians with an initial set of functions.
    - Toll free (1-800 number) access to information and assistance specialists providing resources, programs and services available in their local communities for seniors and people with disabilities, as well as their family members and friends, neighbors and health professionals. This function will include a referral to an appropriate entity to meet the needs of the caller as available.
    - Enhancement and continued support of the website and on-line resource database which includes public and private resources available for seniors and people with disabilities. This searchable database will be available to information and assistance specialists as well as the general public who have Internet access.
    - Statewide use of the on-line contact and database system by AAAs and CILs (with feasibility for CIL use having been conducted/determined) by their information and assistance staff to document calls, requested information and provide a management tool to identify the prominent needs and requests for specific areas.
    - Training of ADRC staff, and their community partners, as appropriate, to use a validated risk tool to identify consumers at-risk of Medicaid spend-down and assure the reliability of data to measure the effectiveness of services to prevent or delay entry in to Medicaid.

- Training provided AAA and CIL staff, as appropriate, for national certification of Information and Assistance staff.
- Medicaid screening and referral as appropriate to the local Medicaid agency for stream-lined access to public benefits and support the matching of federal funds.

- Phase II: By December 31, 2013 additional functions/resources will be available statewide through all ADRCs provided either directly by the ADRC or through developed partnerships with other local providers/partners. These additional functions include:
  - The remaining ADRC core services of Options Counseling, Person-Centered Transition Support and Evidence-Based Health Promotion programs.
  - Financial planning information and referral to services including:
    - Benefits of long term care insurance
    - Pros and cons of reverse mortgages
    - Screening tools/surveys to assist individuals and families determine risks, strategies and methods to manage income, assets, savings and prevention
  - Enhance and expand local resources to promote and assist self-advocacy, self-direction and additional resources/information to help individuals remain in their communities.
  - Provide services and information to assist family caregivers, which will strengthen the natural support system, through information and assistance, training, support groups, counseling and respite.

Oregon Project Independence (OPI)

Created in 1975, OPI serves individuals who are 60 years of age or older, or who have been diagnosed with Alzheimer's disease or a related disorder. The program offers many services, most notably in-home supports, for those meeting certain service eligibility requirements.

Although OPI is thought of as an in-home services and supports program for the non-Medicaid population, House Bill 3037 (2011) expanded other possible services that could be included in the program, such as information and referral services, health promotion services, options counseling, and transportation options to assist individuals to stay in their own homes. Since 2005, the program has a provision to expand eligibility to younger adults with disabilities if there is adequate funding (ORS 410.435).

As a program paid for by General Funds and by many participants who pay for a portion or all of their services, OPI is vulnerable to fluctuations in the state budget. Recently, the program closed to new enrollees. Realizing these factors, the group recommended that the future thinking about OPI should consider it on a "continuum of strategies of care, supports and services" rather than a "stand-alone" program. OPI can play an important role in preventing or delaying Medicaid eligibility as a service of the ADRC discussed above, as well as with the CCO infrastructure established by HB 3037. This important shift in thinking about OPI may provide opportunities to leverage these state funds with federal funds.

Recommendations – OPI

Short term recommendations include:

- Create a report that includes the following information:
    - For individuals with a Service Priority Level (SPL) of 10, compare the average Medicaid cost per case (regardless of setting) with the average OPI cost per case. The report will include the cost of the Oregon Health Plan for individuals on Medicaid, and only includes a comparison of General Fund costs.
    - Identifies the aspects of the OPI program that contribute to the social factors of health, such as nutrition, cleanliness of the personal environment, and socialization.

Longer term recommendations include:

- OPI funded to a level that allows for the participation of younger persons with disabilities and fulfills the requirements of ORS 410.435.
- As Care Transition programs are established in the state, use OPI an integral component of all Care Transitions programs in the state. This is one area in which OPI can coordinate with the transition programs established under the CCOs.
- Fund a study that will show the effectiveness of OPI and other non-Medicaid programs as resources to divert people from Medicaid. Minnesota's Alternative Care program is similar in structure (and larger in scope) to OPI, and may provide a methodology through which to analyze effectiveness of Medicaid diversion.

Risks for Medicaid Eligibility

In addition to the role of the ADRC as a structure to access important services such as OPI by the non-Medicaid population, the group had other recommendations to

mitigate health and behavioral, social and environmental, and financial risks that contribute to individuals spending down to Medicaid eligibility.

Recommendations – Health and Behavioral Risks

Intermediate Outcomes (1-2 years)

By 2014, a targeted number of seniors and people with disabilities defined as "non-Medicaid," and who have accessed the ADRC, have reduced the health and behavioral risks that would have contributed to their entering the Medicaid program.

Goal:

Seniors and people with disabilities, family members and family caregivers are receiving the information and support they need from an ADRC to make informed decisions about decreasing their health risks for entering the Medicaid program

Recommendations to achieve this goal:

- Ensure that ADRC staff use a validated screening tool over the phone or in person to identify the target population and their risks for out of home placement and Medicaid eligibility.
- Ensure that ADRC staff demonstrate the knowledge, skills and abilities to guide at-risk individuals through a risk management and planning process that helps them address areas of risk and links them directly to risk improvement interventions (e.g., Family Memory Care, falls prevention programs, Living Well with Chronic Conditions, caregiver assessment and consultation) and other community resources and supports such as Peer Mentoring Services and/or mental health and addictions services.
- The ADRC will have at least one Participation Agreement in place with a local health care provider (Primary Care Practice, hospital, skilled nursing facility) that establishes a referral pathway to the ADRC for patients who meet the target population definition.

Other ADRC recommendations with a longer time frame for completion:

- Implement evidence-based care transition programs coordinated between ADRCs and hospitals or Skilled Nursing Facilities, and, in concert with

CCOs, to help older adults and people with disabilities avoid an unplanned re-admission or Emergency Department (ED) visit during a 30-day recovery period.

- Pending legislative approval of Coordinated Care Organizations, pursue Participation Agreements between the ADRCs and local CCO entities to support meeting selected standards for Patient Centered Primary Care Homes (see especially Care Coordination and Education and Self Management Support).

Recommendations at the state level:

- Strengthen employment programs and employment supports for individuals with disabilities and seniors who want or need to work, given the positive correlation with employment and health outcomes and the resources that can avoid or delay Medicaid covered services. Employment delays Medicaid eligibility because of access to health care and resources. This support includes assistive technology, workplace accommodations, and personal care assistance.
- For those who need personal care assistance that private insurance does not cover, Oregon's Medicaid Buy-In program, the Employed Persons with Disabilities program, can keep individuals with disabilities competitively employed while they pay a portion of their Medicaid services, as well as taxes and a lower need for subsidies such as housing, transportation, food, and other needs.
- Prioritize Title IIID and IIIE Older Americans Act (OAA) funds to support evidence-based health promotion programs that reach a wider population of at-risk older adults (falls prevention, nutrition counseling, physical activity, medication management, family caregiver support), and pursue strategies to extend these programs to younger adults with disabilities.
- As the development and implementation of CCOs unfolds, the department should work with Addictions and Mental Health and stakeholders on possible models for mental health and addictions services for seniors and individuals with disabilities who are not eligible for Medicaid.
- Develop an agreement between the Conference of Local Health Officials (CLHO), the Oregon Association for Area Agencies on Aging and Disabilities (O4AD), and CILs that incentivizes ADRCs to partner with their local public health department to field community health improvement assessments. (Local public health departments must produce an assessment as part of the process of obtaining accreditation.) These assessments will

survey representative consumers to collect data that measures factors such as:

- Barriers to physical activity
- Access to healthy food
- Access to adequate health and mental health services
- Access to adequate transportation, including transportation during evenings and weekends.
- And other topical areas that the partners wish to measure.

Recommendations – Social and Environmental Risks

Intermediate Outcomes (1-2 years)

By 2014, a targeted number of seniors and people with disabilities defined as "high-risk" for Medicaid and who have accessed the ADRC, have reduced the social and environmental risks that may have contributed to their entering the Medicaid program.

Goal:

Seniors, people with disabilities, family, friends, and caregivers are getting information and support from the ADRC to decrease their risks of isolation and lack of natural supports.

Recommendations that will achieve this goal:

- Complete a review of existing programs in Oregon staffed by volunteers (e.g., RSVP, Project Reach, etc.) that documents the following:
  - Services provided, including gate-keeping to community-based programs;
  - Volume of services provided;
  - Service outcomes;
  - Best practices used to recruit, develop and support volunteer staff; and
  - Recommendations for expanding programs with known outcomes.
- Fund a comprehensive study of the Family Caregiver Support Program begun in 2006 by Older Americans Act funds. In so doing:
  - Examine programs for evidence based and best practices both in Oregon and in other states.

    - Explore current and potential programs that can also serve younger individuals with disabilities, including peer support programs.
    - Convene a group of senior and disability advocates to develop a statewide plan for respite programs.
- Promote the work of the Oregon Real Choice Systems Change Grant – Building Sustainable Partnerships for Housing with the overall goal of eliminating barriers to accessing housing for individuals with disabilities.
- Pursue employment programs for seniors and individuals with disabilities who want or need to work, and strengthen volunteer programs for those who wish to volunteer. Employment and volunteering are key to those who are at risk of social isolation.

Other recommendations with a longer timeframe for completion:

- ADRCs should continue to explore opportunities for coordinated social and medical services that, to the greatest extent possible, can be provided to seniors and individuals with disabilities locally and, if necessary, where consumers live.
- ADRCs should strengthen peer mentoring (whether provided by the CILs or the CILs in concert with ADRCs) in resources for Independent Living, such as skills training, and knowledge of and access to assistive technology and adaptive equipment.

Recommendations – Financial Risks

Intermediate Outcomes (1-2 years)

By 2014, a targeted number of seniors and people with disabilities defined as "pre-Medicaid," and who have accessed the ADRC, have reduced financial risks that may have contributed to their entering the Medicaid program.

Recommendations to achieve this outcome:

- Ensure that ADRC staff and volunteers will be trained to identify individuals possibly at risk for financial fraud, abuse, or exploitation and refer to the appropriate agency.
- Pursue the inclusion of long term care insurance as part of the health insurance exchange that will be created by 2014 in Oregon.
- Partner in publicizing long term insurance policies with employers who offer it, as well as the state's Long Term Care Partnership program.

- Include the Department of Consumer and Business Services in exploring initiatives to expand money management education programs to the non-Medicaid population.
- Explore initiatives to expand the use of cash and counseling (self-direction) for services to the non-Medicaid population, such as those supported by OAA, OPI and Veterans-Directed Home and Community-Based Services (VDHCBS). VDHCBS was recently implemented by the AAAs serving Multnomah and Washington counties.
- Pursue advocacy at the federal level for reinstating the implementation of the Community Living and Assistance Services and Supports (CLASS) Act. Also pursue a possible CLASS Act program at the state level.

Subsections (2) and (3): Recommendations for Individuals who are Eligible for Medicare, Medicaid, and Medicaid LTC

As stated in the introduction, the new state statute in HB 3650 and the possibility of blending Medicare and Medicaid funding provides opportunities for coordinating the physical, behavioral, and oral health care of individuals dually eligible for Medicaid and Medicare. Also noted was that HB 3650 excluded Medicaid funded LTC from the purview of Coordinated Care Organizations (CCOs).[5]

Parallel medical and LTC systems: The medical system and LTC system have parallel service delivery systems, leading to fragmented care for beneficiaries. Without coordination and alignment between the two systems, some services are duplicated or denied in one system even if they may provide savings and improved coordination with the other system.

It is possible that the maintenance of two separate systems will continue to produce misaligned incentives, cost-shifting between the CCOs and the LTC system, and poor outcomes for beneficiaries. Both systems are also informed by different models regarding aging and disability, the medical model and the social model, with their differing conceptions of the role of professionals, individual and consumer choices, and risk.

[5] Despite this exclusion, it is important to note here that HB 3650 provides for CCO criteria regarding transitional care for individuals who enter or leave acute care facilities of a long term care setting, and for CCOs to use health information technology to link services and care providers across the continuum to the greatest extent practicable.

Given the exclusion in HB 3650 of Medicaid-funded LTC from the CCOs, the question facing the group for subsection (2) and (3) is: How can we strengthen the relationship, and create mutual accountability, between services provided under the CCOs and LTC services provided by the Department of Human Services, Aging and People with Disabilities programs?

In addressing these issues of coordination and accountability, the group looked at:

(2) Best blend of resources to ensure access: Specific plans and recommended steps to best blend state and federal resources with private pay to assure access to high quality care and supports for individuals, families and caregivers.

(3) Alignment, efficiencies, and incentives to ensure outcomes: Plans and recommended steps to better align state and local administrative structures, identify cost efficiencies and create incentives to assure consistent, efficient and effective service delivery and high quality service outcomes.

Best Blend of Resources to Ensure Access

The group tackled this topic in several ways. First, the group identified alternative resources that could be used with more flexibility, and made recommendations for better leveraging private contributions. In addition, the group considered the specific blend of resources provided by the CCOs and LTC systems, however, those findings and recommendations also relate to the groups charge to identify efficiencies and incentives to ensure outcomes, and are captured toward the end of that section.

Recommendations – Flexible Use of Resources:

The group considered the full array of resources available to support individuals eligible for Medicare, Medicaid, and LTSS, by first identifying the federal, state, community, and private resources and services available to support these individuals. See Appendix B for an inventory of these resources. The group noted that some of these resources had a large positive impact on outcomes for individuals and savings to the system, yet were not used as effectively as they could be:

- Seek changes for more flexibility in purchasing and procurement of Durable Medical Equipment (DME). Flexibility in purchasing DME could improve independence and health outcomes. Explore the ability to reclaim and reuse DME while ensuring safety and liability protections.

- The non-emergent medical transportation system in many communities is not designed to meet urgent, unscheduled care needs. Opportunities to provide access to early intervention and prevention services are lost, resulting in increases use of ambulance and emergency room use.
- Adult day centers are an underutilized alternative LTSS that could reduce Home Care Worker hours, provide socialization and respite, improve nutrition, and allow earlier identification of potential health and functional issues.
- Increase the capacity of LTC system to provide placements, services, and supports for individuals with severe behavioral service needs.

In addition to identifying opportunities related to these resources, the group highlighted some specific recommendations around leveraging private contributions more effectively.

Leveraging Private Contributions:
Regarding the best blend of private resources, the group first identified changes in Medicaid that could create either new opportunities for federal Medicaid match or new savings, for example, by incentivizing individuals to purchase long term care insurance.

Recommendations – Leveraging Private Contributions:

- Explore flexibilities to use private contributions as match for federal funds, by increasing the individual's contribution to services, and lowering their contribution toward room and board in community based care settings. The individual's contribution to services is eligible for federal match, whereas their contribution to room and board is not.
- Pursue flexibilities with CMS to allow the use of supplemental payments without jeopardizing Medicaid payment for LTC and while ensuring consumers are protected. In several states, it is possible for family members to contribute supplemental service payments for a private room in a community based setting, for example. Oregon currently does not allow supplemental payments.
- Leverage Long Term Care Insurance via flexibilities with CMS. DHS and OHA should work to expand and improve on the existing Long Term Care Partnership Program.

Alignment, Efficiencies, and Incentives to Ensure Outcomes

The group developed recommendations for better aligning and coordinating between the Coordinated Care Organizations (CCOs) and Long Term Care (LTC) systems. Recommendations identifying efficiencies and incentives needed to ensure outcomes are addressed on pages 27-29.

Alignment and Coordination between CCOs and LTC Systems:

To begin, the group discussed promising models and pilot projects in Oregon for better service coordination[6] between the medical and LTC systems. These practices are not exclusive and can be combined.

Promising service coordination models between CCO and LTC:

- Co-Location or Team Approaches – Some examples include:
  - Lane County pilot program where the Medicaid managed care plan has a psychiatric nurse practitioner located in the local AAA office, who consults with providers, individuals and case managers.
  - LTC case managers in medical settings (hospitals or primary care),
  - Service coordination positions jointly funded by the LTC and medical systems, or
  - Team approaches such as an interdisciplinary care team including LTC representation.
- Services in Congregate Settings - Includes models where a range of LTSS and medical services are provided in congregate settings to a group of common beneficiaries. In these models, services can be:
  - Limited to one type of service such as 'in home' personal care services provided in a congregate setting or
  - A comprehensive model such as the Program for All Inclusive Care for the Elderly (PACE) program where all LTSS and medical services are capitated and delivered by an eight-member interdisciplinary team.
- Clinician/Home-Based Programs - These include increased use of Nurse Practitioners, Physician Assistants, Registered Nurses and/or Geriatricians who perform assessments, plan treatments, and provide interventions to the person in their home, community-based, or nursing facility setting. PACE includes clinician home based programs for individuals receiving care in the home.

[6] For purposes of this report, "service coordination" is defined as an inclusive category of social and medical services; "care coordination" is a subset of service coordination.

- Service Coordination- This is an essential component in all of the above projects but can be a stand-alone model. While the actual practices vary, care coordination models use defined protocols and reexamination of staff roles to promote person-centered care, improve sharing of information and alignment of critical assessment, service planning and interventions.

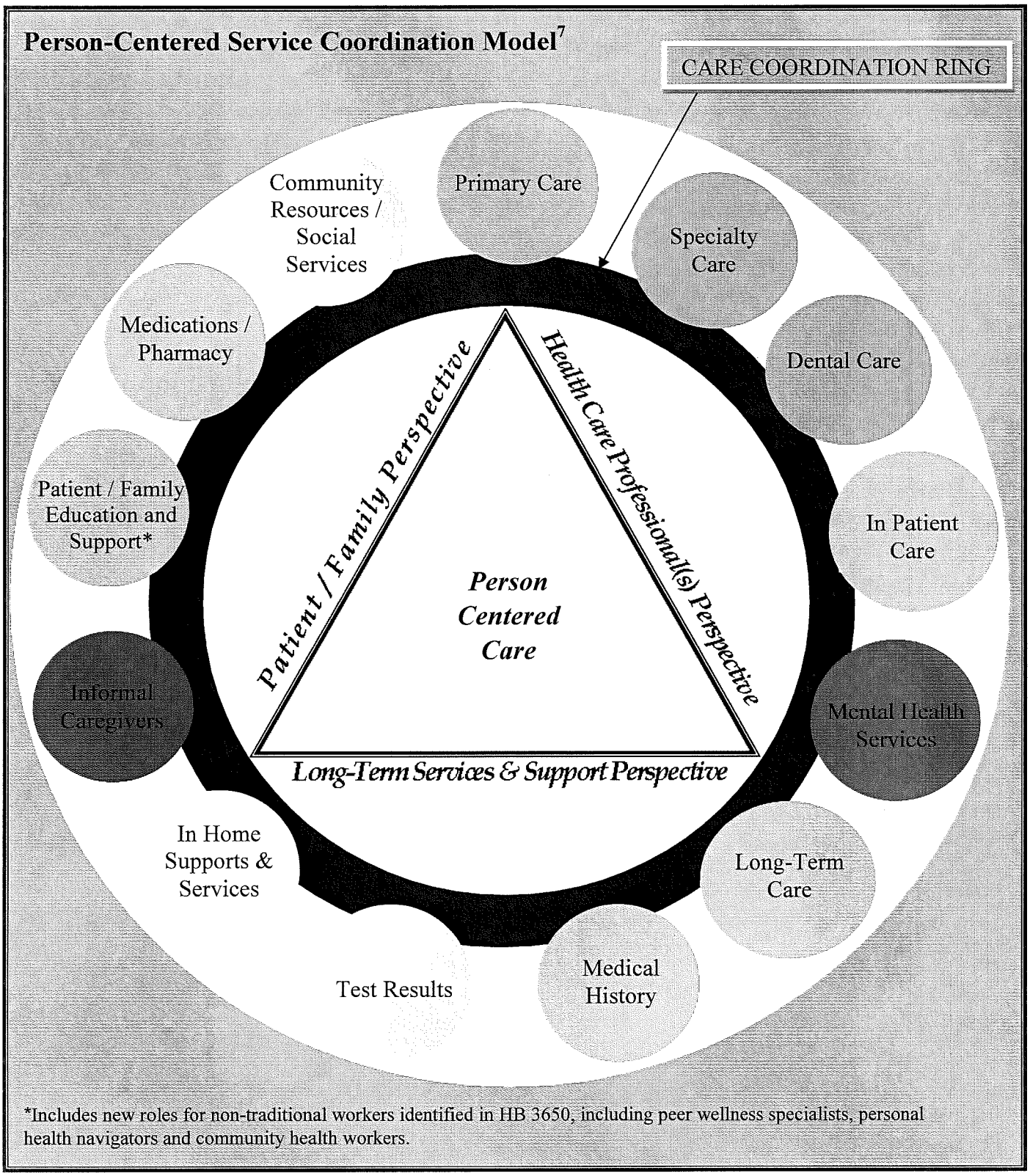
On the latter point of service coordination, the group discussed extensively the problems of cost shifting (see pages 45-46), as well as very practical considerations of implementing and codifying best practices of coordination between the medical and LTC systems.

Key Recommendations for Service Coordination:

1. Expectations for coordination are formalized through state level CCO contracts, Area Agencies on Aging (AAA) Intergovernmental Agreements (IGA) as well as memoranda of understanding/contracts between the CCO and LTSS partners.
2. Communication practices are essential to successful care coordination practices. These include immediate information sharing protocols as well as the long-range goal of statewide electronic record sharing systems.
3. The state should provide guidelines and expectations for the effective education of individuals, providers and systems to facilitate better coordination and service delivery and informed engagement of individuals in their care.
4. Reduce duplicative practices in assessments, service planning and medical procedures in addition to emphasizing service coordination at transition points between long term and acute care, and for all high needs individuals.
5. Make available an Interdisciplinary Team approach (see illustration on the following page) that includes LTSS and CCO representation particularly for individuals who are most at risk and those in transition. This process must be person centered.
6. Ensure that reimbursement and regulatory mechanisms are provided as a framework to support participation in service coordination.
7. Include, and engage individuals so that they can be responsible for their choices and the goals of their care.
8. Transitions should be effectively managed between different levels and systems of care (acute, nursing facility, mental health and home and community) using best practices as well as innovative approaches.

9. Ensure that CCOs and the LTC system have coordinated after-hours access to advice, services and appropriate medical care. Use contracts to specify how this will be accomplished.
10. Explore and pursue models that integrate service provision and coordination. These may be new models or existing models with new flexibility: examples include Co-Location, Services in Congregate Settings (including PACE), and Clinician-Home Based Programs (see page 20). Provide additional flexibilities to existing LTSS providers that allow them to creatively test new models of care.

The following visual, based on a model published by the federal Agency for Healthcare Research and Quality (AHRQ), illustrates the model recommended by this report for services coordination. The person in the center reflects the person-centered approach the group recommends. According to AHRQ, "the *central goal* of care coordination is shown in the middle of the diagram. The *colored circles* represent some of the possible participants, settings, and information important to the care pathway and workflow. The *blue ring* connecting the *colored circles* is CARE COORDINATION—namely, anything that bridges gaps (white spaces) along the care pathway (i.e., care coordination activities or broad approaches hypothesized to improve coordination of care."



[7] This visual is a modification of the Agency for Healthcare Research and Quality (AHRQ), "Care Coordination Measures Atlas" (http://www.ahrq.gov/qual/careatlas/careatlas.pdf)

Key Elements of Service Coordination:
The group explored key elements in service coordination in order to recommend best practices in its implementation. These elements included assessments, integrated service plans, interdisciplinary service teams, and communication.

Assessments:
An assessment is a process where a particular professional gathers clinical, regulatory or payment related information on a specific individual. In an integrated assessment process, information is shared across disciplines or settings for use in a common service plan. This requires formal information sharing agreements.

Recommendations - Assessments:

- Assessments must be person centered and address the whole person. Information gathered in assessments needs to:
    - Identify each individual's strengths, needs and goals.
    - Support and improve an individual's engagement and personal responsibility.
    - Identify social determinants of health, including caregiver and family supports, home environment, individual lifestyles, community inclusion, and access to transportation.
- Assessment data should be comprehensive enough to allow for prioritization of services, support service coordination and provide information needed by all members of the interdisciplinary team.
- Create a screening or risk assessment system to identify and assign high-risk, vulnerable enrollees to intensive service coordination and to differentiate service needs among beneficiaries.
- DHS and OHA need to explore ways, including waivers, to minimize the state and federal requirements that result in duplicative assessment processes with the goal of creating a standardized process across the CCO and LTC systems. Such exploration should include looking at the pilot projects/challenge grants being funded by the federal Department of Health and Human Services to improve the sharing of assessment data across acute and LTC settings electronically.

Integrated service plans:
An integrated service plan provides the framework for effective service coordination implementation. These plans are developed to meet the needs of the individual identified in the shared assessment process.

Recommendations – Integrated Service Plans:

- The integrated service plan should be person centered and identify supports needed to ensure that the individual is activated and empowered to engage in health promotion, prevention and disease self management.
    - The integrated service plan must build on information gathered in assessments including individual strengths, goals and needs, including community participation.
    - The plan should include an individual's preferences for care, including identification of an individual's desire for palliative interventions.
- Integrated service plans should combine information from LTSS with information from any provider within the CCO's delivery system network. The plan must follow the individual receiving care and be updated over time.
- The integrated service plan should include robust crisis service planning. It should contain information necessary to support behavioral health related emergencies even with diagnoses such as Traumatic Brain Injury or dementia.
- The plan should ensure that supports are identified to provide culturally appropriate interventions and communication.

Interdisciplinary Service Teams:
Integrated service plans are developed and carried out by an interdisciplinary team (IDT). Membership is determined by the individual needs, services and goals defined in the service plan.

Recommendations – Interdisciplinary Service Teams (IDT):

- IDTs must be supported by aligned incentives, contract requirements with CCOs and LTSS providers and Intergovernmental Agreements (IGAs) with Area Agencies on Aging.
- A method for adjudication of disagreement is needed within the IDT. This should occur locally at the lowest possible level.
- The IDT must be culturally appropriate and person centered

<u>IDT Roles and responsibility:</u>

- IDTs are responsible for coordinating all aspects of an individual's care with an emphasis on transitional care. IDTs must assess the full care spectrum, including medical, long term care, behavioral, and dental health, in part to ensure treatments and services are not duplicative or in conflict.

- Members of the IDT must communicate regularly (at least every 6 months) or when there is a change in condition, either virtually or in person, for the purpose of coordinating care.
- IDT must be able to authorize both LTC and CCO resources to align with population needs.
- IDT accountability for outcomes, risk or cost needs to be defined and understood by all members.

IDT Membership:

- Procedures and protocols are needed to assign individuals to teams with appropriate levels of membership and intensity of oversight. These should be based on risk, vulnerability, or service needs.
- Members of the IDT should include:
    - A care coordinator lead with responsibility for critical service coordination activities. There must be allowance for individual choice and accommodation of preference when designating the service coordinator lead.
    - Providers of health care and LTSS.
    - Members of the non-traditional workforce such as peer wellness specialists, health system navigators and community health workers.
    - The individual and their family or caregivers.

Recommendations – Education

- Both CCO and LTSS staff and providers will need education to support person centered care, a shared mission, establishment of shared goals and promotion of a culture of understanding and respect across disciplines.
- Education and information should be consistent and non-duplicative between the CCO and the LTC system. The goal is a seamless experience for the consumer.
- Individuals and family members or representatives may need education and support to:
    - Understand their role and the implications and outcomes of the decisions that they make around their care.
    - Promote personal responsibility and active participation in personal health care goals.
    - Understand service planning and care coordination processes.

Communication:

Recommendations in Assessment and Interdisciplinary sections will support improved communication practices between individuals, providers, IDT members

as well as LTC and CCO system level partners. The following recommendations were also identified.

Recommendations – Communication:

- Communication processes need to be established for sharing information including: Medicaid authorizations, LTC eligibility assessments and individualized service plans generated by LTC providers, the CCO and other delivery system network providers (e.g. mental health treatment plans).
    - CCOs need to know when members are receiving LTC services and have triggers in place to set up service coordination activities.
    - The LTC system needs to know when the CCO has identified a person who is in need of LTSS. The CCO must have documented processes for identification of those individuals and processes for timely referral to the LTC system for assessment and LTSS interventions.
- Communication practices and systems can and need to be developed independent of electronic records systems so that privacy barriers don't prevent care coordination.
- Continue efforts to develop Health Information Exchange systems, but we should not wait to improve sharing of information.
- Need to create a common language and understanding of terminology between systems.

Other Alignment and Coordination Recommendations
The group included some additional recommendations on alignment and coordination.

Recommendations- Other Alignment and Coordination

- CCOs must demonstrate that, in concert with the LTSS providers, they have a plan and an adequate system of monitoring the health status of individuals being served. This includes a systematic approach to surveillance, early detection and early intervention to prevent further functional decline and costly care.
    - Establish a process for monitoring service coordination successes and failures and ensuring accountability across the CCO and LTC system.
- Service coordination activities should be expanded to Patient Centered Primary Service Home (PCPCH) models as they are established.
- Create a pool of resources that can be used when the IDT agrees that purchase of equipment or other services is necessary but does not fall under Medicare or Medicaid payment guidelines would be beneficial.

- Standardize requirements in contracts and intergovernmental agreements to provide a minimal set of requirements to meet the needs of individuals who receive LTC but flexible enough to support models in rural areas or other community specific needs and partnerships.

Efficiencies and Incentives to Ensure Outcomes between CCOs and LTC Systems:

In addition to the recommendations on coordination, the group considered efficiencies and incentives to ensure outcomes. The group considered first the problems of cost shifts between the LTC system and the medical services provided under CCOs. Then the group identified outcomes metrics and mechanisms for shared financial accountability to create efficiencies and incentives to ensure outcomes.

Potential Cost shifts between CCOs and LTC systems:

Appendix C includes an inventory of potential cost shifts between the LTC and CCO systems that were discussed by the group. Some of these cost shifts and other inefficiencies are illustrated below:

Cost shifts from LTC system to CCOs:

- Lack of communication from the LTC system to the health plan about changes in individuals' status limits the ability of plans to effectively manage medical care for those individuals.
- CCO may not control the types of setting individuals discharge to; PAS screenings[8] and individual choice may result in individuals placing into lower levels of care than medically appropriate leading to failure of the LTC placement and possible readmission to the hospital.
- Lack of community support and respite care for family members, particularly related to behavioral health needs, leading to increased emergency room utilization.

Cost shifts from the CCO to LTC system:

- Durable Medical Equipment can be important to ensuring that individual is able to live independently and lack of access to this equipment can increase LTC system costs such as increased need for assistance with activities of daily living.

[8] The Pre-Admission Screen (PAS) generally refers to the process that DHS uses to determine an individual's eligibility for Medicaid-funded LTC services.

Other related drivers of increased costs and inappropriate emergency room utilization and hospitalizations include:

- Physicians and other health care providers, especially psychiatric providers, are not paid to deliver services in LTC facilities resulting in lack of access, lack of treatment or under treatment which results in increased use and more expensive services such as acute inpatient services.
- Lack of 24-hour services and lack of transportation services are additional factors driving Emergency Room usage by individuals receiving LTC.
- Poor post acute care coordination results in individuals not receiving the appropriate intensity and amount of care, and services not being coordinated, leading to worse outcomes and potential avoidable readmissions.
- In addition to readmissions to the hospital, failed LTC placements may be associated with a range of costs such as DME purchases and personnel costs.

Metrics and outcomes:
The group was asked to consider how metrics should be used in supporting the goal of system accountability between the Long Term Care System and CCOs.

Recommendations – Metrics:

- Both outcome and process measures should be developed and used to support system accountability.
- Process measures should ensure coordinated service planning and transitions of care. Suggested process measures include:
    - Completion rates for person-centered service plans, and evidence that the individual to be served was engaged in service-planning,
    - Evidence that the service plan was followed across system partners,
    - Evidence that education was provided to the individual,
    - Evidence that individuals were offered advanced care planning, including of Physicians Orders for Life Sustaining Treatment (POLST), or Advanced Directives, and
    - Evidence that transitions of care were effectively managed including timely and accurate, transfer of clinical information and status changes between the LTC system, the CCO and providers within the CCO's delivery system network.
- Outcome measures should demonstrate that CCOs and the LTC system had been effective in working together to ensure that an individual's health, functionality, and well-being are maximized, understanding that some individuals would be expected to improve, while for others, a positive

outcome would be maintaining function and health or reducing the rate of decline. Suggested outcome measures include:
    - A healthy days measure,
    - Rate of return to home, as defined by the beneficiary,
    - Rate of inappropriate emergency room utilization, hospitalizations, or readmissions – or, ideally, a holistic measure looking at utilization patterns to support the triple aim,
    - Rate of medication adherence,
    - Improvement or maintenance in Activities of Daily Living or level of functioning, and
    - Satisfaction of individuals served.
- Measures should be appropriate to the population and the goals of care. The metrics that are most appropriate in one population may not be appropriate for another population, based on differences in the health status and expected trajectory of each group, as well as the goals of care for that population. For instance, while improving or maintaining function is an important goal for a major part of the population, it may not be appropriate for those with severe chronic and/or health conditions, and particularly for those in or nearing end-of-life.
- Measures may need to be risk-adjusted to avoid creating disincentives to serve high needs individuals. At the same time, this risk adjustment must be implemented in a way that is mindful of the need to also create incentives to improve the health of the population rather than accepting the status quo.

Sharing financial accountability:
Given these potential cost shifts, the group was presented with financial models that might mitigate them. Members of the subgroup supported the idea that there needed to be financial models to support coordination between CCOs and LTC, with more support for incentives or shared savings than for penalties or shared risk. In particular, concerns were raised about sharing risk with providers for costs that they might not be able to control, or for which they were not solely responsible.

Recommendations – Sharing Financial Accountability:
- Positive financial incentives should be put in place, particularly shared savings and incentive payments tied to desired outcomes.
- There should be incentives to encourage process/structure of coordination across the two systems, such as participation in integrated service teams.

- To the extent feasible, shared savings and incentives should be locally determined, possibly through a negotiation between the CCO and the LTC providers/system in the area.
- Some types of penalties may be appropriate, such as not paying for duplicative services when providers are not following the care plan.
- Individual smaller providers including home care workers and adult foster homes are not appropriate for penalties/sharing risk.
- Consider how to address issues of individual responsibility and particularly individuals that refuse reasonable care in putting in place shared accountability for performance.

Other Recommendations for Efficiencies:

- OHA and the CCOs should work with CMS to waive the 3-day prior hospital stay requirement for skilled nursing facility services under Medicare.
- Encourage CCOs to explore ways to be more flexible in allowing services to be provided in alternative settings, breaking down barriers to person-centered care.

Conclusion

The department and its external stakeholders appreciate the opportunity the 2011 Legislative Assembly gave to plan for the future of the long term services and supports in Oregon. In light of the changes inherent in Health System Transformation, the relationship between the Long Term Care system and the establishment of Coordinated Care Organizations is paramount in providing effective and efficient services and supports to seniors and individuals with disabilities. These recommendations are intended to orient the department and its stakeholders to planning this future under the circumstances of limited resources. We will use these recommendations to keep our planning process accountable to the Legislature, and the department appreciates any feedback the Legislature may have.

Appendices:

A. Inventory of Long Term Care and Community Resources
B. Areas of Misalignment & Risk that May Invite Cost-Shifting

APPENDIX A

Inventory of Long Term Care (LTC) and Community Services

The purpose of this listing is to provide a beginning overview of the services and supports that are needed and or utilized by seniors or persons with physical disabilities.

	(Funding Sources)				
	State	**Federal**	**Private Pay**	**Other (local, non-profit)**	**Notes**
LTC Placement/Services and Supports					
Medicaid Financial/Service Screening	General Fund (GF)	Medicaid			
Older American Act (OAA)* Information/Assistance/Outreach	GF	OAA/Medicaid			In AAA/Medicaid offices funding is blended for Medicaid screening and referral and information and assistance
Veterans Affairs (VA)– Aid & Attendance (payment to help cover home and community based services) VA Nursing Home.		Veteran's Affairs (VA)			May provide offset or supplemental services to triples who have service related disabilities.
Case Management (CM)- Authorization of Services HCBS, OHP, Service Rates, In Home Hours, Durable Medical Equipment, Transportation, Special Needs, Nursing, all settings	GF	Medicaid/ OAA			
CM -Monitoring, Assistance with residential placements or in home supports. Problem Resolution, Crisis Response, all settings	GF	Medicaid/ OAA			
CM- Coordination with families, in home care, medical, residential and nursing providers, all settings	GF	Medicaid/ OAA			This function is not provided consistently throughout state and may be provided by nurses or licensed residential provider.

	State	Federal	Private Pay	Other (local, non-profit)	Notes
Contract Nursing –Assessment, Service Plan, Teaching Delegation, Coordination	GF	Medicaid			
Medicaid In Home Services – Spousal Pay, Independent Choices, Client Employed Providers, Agency	GF	Medicaid			
Specialized Living Apt	GF	Medicaid			Population specific
Oregon Project Independence (OPI)– In-Home Services/Day Care	GF		Individual pays on a sliding scale		
OAA Personal Care, Homemaker and Chore services (typically augments OPI funding)		OAA			
Personal Care 20 hours (PC20)	GF	Medicaid			Individuals not eligible for LTC full benefits may be eligible for 20 hours of assistance. Available through SPD/AAA and County Mental Health
24 hour Residential Services - Adult Foster Home, Residential Care and Assisted Living Services, Alzheimer's, Special Needs/Pop Contracts.	GF	Medicaid			
Nursing Facility- long term	GF	Medicaid			
Adult Day Care	GF	Medicaid			
OAA Adult Day Care		OAA			
OAA Respite services		OAA			
Program of All Inclusive Care for the Elderly (PACE)	GF	Medicaid/ Medicare			
	State	**Federal**	**Private Pay**	**Other (local, non-profit)**	**Notes**

Long Term Care Insurance – covers home and community based care and/or Nursing Facility			Personal Income/ Resources		See note below chart under innovations
State Independent Living Council – consumer-directed model of peer support, information and referral, skills training, and advocacy	GF	Title VII			Some services may not be available in all areas.
Medical Services and Supports					
Oregon Health Plan	GF	Medicaid			
Veterans Affairs Medical Services		VA			
Parish Nursing				Volunteer ministry	Usually delivered through churches.
Senior Health Insurance Benefits Assistance (SHIBA)- Medicare enrollment		Medicare		Volunteer	May be provided through partnerships with AAA or not for profit agencies.
Oregon Prescription Drug Program					Group purchasing discount program.
Medication Assistance				Pharmaceutical Companies/ non-profits	
Medicare-Medicaid Package**					
Durable Medical Equipment, prosthetics, orthotics, and Supplies	GF	Medicaid/ Medicare			Where Medicare is listed under the DMAP services Medicare is primary payer/Medicaid secondary payer.
Nursing Facility – Post Acute	GF	Medicare/ Medicare			
Administrative Examinations and Reports	GF	Medicaid			
	State	**Federal**	**Private Pay**	**Other (local, non-profit)**	**Notes**
Ambulance Services	GF	Medicaid/ Medicare			
Dental services	GF	Medicaid			

Federally Qualified Health Centers	GF	Medicaid/ Medicare			
Home Enteral/parenteral nutrition and IV services	GF	Medicaid/ Medicare			
Home Health services	GF	Medicaid/ Medicare			
Hospice services	GF	Medicaid/ Medicare			
Hospital services	GF	Medicaid/ Medicare			
Rehabilitations Services, such as Physical, Occupational, and Behavioral/Mental Health Therapies	GF	Medicaid/ Medicare			
Medical Transportation services	GF	Medicaid			
Medical-Surgical services	GF	Medicaid/ Medicare			
Pharmaceutical services	GF	Medicaid/ Medicare			
Physician Services	GF	Medicaid/ Medicare			
Private Duty Nursing services	GF	Medicaid			
Renal Services	GF	Medicaid			
Speech-Language Pathology, Audiology and hearing Aid services	GF	Medicaid/ Medicare			
Transplant services	GF	Medicaid/ Medicare			
Vision services	GF	Medicaid			

	State	Federal	Private Pay	Other (local, non-profit)	Notes
Transportation					
Private vehicle			Individuals funds		Vehicle is allowable asset under Medicaid for medical transportation.
Public transportation	GF	Medicaid		Local funds	
Medical and Non Medical Transportation	GF	Medicaid			
OAA Transportation		OAA			
Behavioral Services and Supports					
Residential Services such as, Enhanced Care, and Enhanced Care Outreach Services (ECOS)	GF	Medicaid			Combined Mental Health/SPD.
Clinic based or outpatient mental health services	GF	Medicaid			Combined Mental Health/SPD.
Substance Abuse services – inpatient and clinic	GF	Medicaid			
Mental Health screening and evaluation provided through Pre-Admission Screening and Resident Review (PASRR)	GF	Medicaid			
Nutritional Services and Supports					
Supplemental Nutrition Assistance		USDA			
Home Delivered Meals (Medicaid)	GF	Medicaid			
OAA Home Delivered and Congregate Meals		OAA	Donation		
Food Banks				Donations	

	State	Federal	Private Pay	Other (local, non-profit)	Notes
Housing Services					
Low Income Housing Assistance		HUD		County	State and County based programs not in DHS/OHA.
Retirement Housing- Apt models, non licensed w. meals, housekeeping included)			Personal income/ resources		Medicaid in home services may be provided in these settings.
Elderly Rental Assistance Program					Renters 58 years old or older, household income $10,000 or less.
Other Services and Supports					
Protective Services	GF	Medicaid			Available without regard to income.
OAA Legal Assistance		OAA			
OAA Caregiver Counseling/Support		OAA			
OAA Education		OAA			
LTC Ombudsman	GF	Medicaid			Advocacy and monitoring for persons in licensed settings.
Low Income Home Energy Assistance Program (LIHEAP)		LIHEAP			
Acute care medical team and supports		Medicare			
Volunteer programs					Volunteer usage could lower costs.

***State Older American Act Programs**: These federally funded services are provided to Oregonians aged 60 years or older regardless of income levels. Contributions/fees/donations can be requested for OAA services.

- Older American Act Services are provided by the Area Agencies on Aging (AAA). Some AAAs also operate the Medicaid program. When the local AAA does not operate the Medicaid program then the local SPD office manages the program.
- Aging and Disability Resource Centers (ADRC) are currently being piloted in the AAAs as an expanded service to include the population that does not receive Medicaid. The current pilots have involved, for example, additional education and

certification of Information and Assistance workers, increased options counseling on LTC choices for the non-Medicaid population, increased use of evidenced based education to improve health, prevent losses, and increase independence, and partnerships using evidenced-based approaches to improve hospital transitions and reduce hospital readmissions.

****Medicare – Medicaid Package** is edited and limited list of the most common services utilized by Medicaid-Medicare eligible population.

APPENDIX B

Areas of misalignment & risk that may invite cost shifting

This inventory attempts to capture major areas and sources of cost shifting. This is not an exhaustive inventory and some areas of cost shift may be intertwined in multiple ways. Some causes for cost shift can be attributed to:

- Misaligned financial incentives such that health plans or long term care (LTC) systems do not have financial incentives to reduce cost shifts and invest in appropriate infrastructure, etc.
- Lack of understanding between the social and medical models of care.
- Lack of shared information about an individual receiving care and services between social and medical model providers.
- Misaligned administrative policies and rules that exacerbate these issues.

L= cost shift from LTC **C**= cost shift from Coordinated Care Organization (CCO)

I. Cost shift due to lack of care/prevention:

L- Unnecessary emergency room visits and hospitalization due to:

- LTC placement failure (see below).
- Inadequate care plan.
- Inability to address medical needs in LTC setting.
- LTC providers seeking to avoid liability for failing to address medical needs.
- Lack of 24-hour medical service supports available to individuals in HCBS settings.

C- Poor access to primary care in LTC settings due to lack of reimbursement to primary care providers. This results in increased acuity and intensity of care.

L/C- Lack integrated care planning between LTC and CCO:

- Inadequate supports to ensure person-centered decision-making for individuals that lack the decisional capacity to participate.

L /C – Change of condition leading to premature entry into LTC due to:

- Lack of access to existing community resources.
- Lack of access to behavioral health, addictions treatment, psychiatric evaluations and psychiatric medication review.
- Lack of alternative resources and high LTC eligibility limits.
- Barriers to getting independence enhancing devices (Durable Medical Equipment (DME), adaptive equipment).

L /C - LTC placement failure due to:

- Lack knowledge/education and capacity to care for individuals with mental/behavioral health needs in the LTC system including positive behavioral supports and other environmental interventions.

- Lack of access to behavioral health, mental health, medications, and psychiatric evaluations for people coping primarily with disorders such as dementia and Traumatic Brain Injury (TBI). Due to misaligned financial incentives.
- Lack of clarity when Mental Health Crisis services can or should be used for severe behavioral health disturbances for individuals living in Home and Community Based Services (HCBS) or LTC.
- Evictions from LTC or HCBS following a behavioral health or mental health disturbance while the individual is hospitalized. This typically results in extended acute care stays.
- Lack of specialized services/resources in LTC for complex conditions such as: bariatric care, TBI, dementia, severe behaviors, etc.

II. Discharge from acute care setting:

C- Inappropriate NF utilization due to accelerated discharge planning.

C- Poor hospital discharge planning, post acute care coordination and implementation resulting in:

- Failure of HCBS placement and/or deterioration in condition.
- Increase in Medicaid exceptional payments to HCBS due to:
  - Lack of medical wrap-around services.
  - Lack of behavioral wrap-around services.
- Increase in NF staffing costs due to untreated or undertreated medical conditions and unclearly defined behavioral treatment needs (e.g. delirium).

C- Increase in Medicaid special needs payments for home adaptations and DME due to higher acuity discharge into community.

III. Overlapping Services:

C- Increase in contract registered nursing costs due to decrease or denial of Medicare home health services.

C- Increase in staffing in HCBS due to:

- Denial of DME.
- Lack of behavioral health services.

L/C- Fragmented care coordination and poor transitions due to lack of role clarity, including lack of medication management leading to poly-pharmacy for people with multiple conditions and multiple prescribers.