Oregon
Kate Brown, Governor

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April 30, 2019

DHS Oregon Department of Human Services

The Honorable Senator Lee Beyer, Co-Chair
The Honorable Representative Rob Nosse, Co-Chair
Ways and Means Joint Subcommittee on Human Services
900 Court Street NE
H-178 State Capitol
Salem, OR 97301-4048

Re: Follow-up Questions from April 18, 2019 Hearing

Dear Co-Chairs:

Thank you for the opportunity to testify on April 18, 2019. We have addressed the Committee's follow-up questions below.

How do the Aging and People with Disabilities adult foster home rates compare with the Addictions/Mental Health and Intellectual/ Developmental Disabilities rates?

First, let me apologize for my misunderstanding around how the rates for Addictions and Mental Health programs compare to APD's. Below are the average monthly rates in the three programs:

- **Aging and People with Disabilities:** $2,733 per month.
- **Intellectual/ Developmental Disabilities:** $5,335 per month.
- **Addictions and Mental Health (OHA):** $2,289 per month.

How long does it take surveyors to complete their work at a facility?

Each survey team consists of an average of 2-3 people. The team typically completes the survey/inspection in 3-5 days. Thus far in 2019, 87% of facilities have required 1-2 revisits due to the fact that the facility was found to have not been in substantial compliance with the licensing rules and 13% requiring 3-4 revisits.

The amount of time required to write the report is dependent upon the number of "tags" or deficiencies cited during the survey. Currently, it takes the team approximately 2-3 days to get a report written, reviewed, edited and completed.

What are the top ten TAGs in community-based care?
The following list represents the top 10 most frequently cited tags in community-based care settings. These tags are specific to Residential Care Facilities and Assisted Living Facilities and do not include Memory Care.

- **C270- Change of Condition and Monitoring** - Change of condition refers to both short and long-term changes to a resident's health status, which may include: skin tears, falls, weight loss or gain, medication changes, and behavioral changes among others. Monitoring refers to the requirement for facilities to observe and assess the resident and to revise the resident's care plan to provide appropriate care and services until changes of condition resolve or become permanent.
- **C455- Inspections and Investigations**- This tag is cited when facilities fail to be in substantial compliance during a revisit survey, and as a result, must develop a new plan of correction related to how they will come into substantial compliance.
- **C260- Service plan**- Service plan are plans of care that provide specific directions to staff related to each person's care. This tag is cited when facilities fail to provide service plans that are person-centered and reflective of residents' current status or care needs.
- **C303- Physician orders**- Facilities may only dispense medications and/or treatments with a physician's order, and the facility must include those physician's orders in the resident's chart. This tag is cited when medications are given without a valid order or when the order is not found in the chart as required.
- **C370- Staff Training**- This tag is cited when staff lack required training or documentation that they have successfully completed such training. For direct care workers, this includes documentation of demonstrated competency within 30 days of hire, as well as 12 hours of annual training on provision of care.
- **C310- Medication Administration**- This tag is cited when medication administration records are found to be inaccurate, and/or specific parameters regarding medications used to treat the same symptoms lack clarity.
- **C231- Abuse reporting and investigation**- This tag is cited when facilities fail to report abuse or suspected abuse appropriately to Adult Protective

Services. For example, injuries of unknown origin must be reported unless a thorough investigation rules out abuse. Neglect of care is also considered abuse and must be reported.

- **C 240- Kitchen**- This tag is cited when a facility kitchen is not clean and/or equipment is not sanitary and in good repair.
- **C280- Resident Health Services**- Most frequently, this tag is cited when the facility RN fails to assess all residents with a significant change of condition, such as: significant weight loss or gain, open pressure sores or other skin issues, change in status related to care needs, sudden confusion or behavior changes, or falls with fractures.
- **C252- Evaluations**- This tag refers to requirements for evaluation and assessment of resident status, both at move in and ongoing as required. The facility must document required components of the evaluation prior to move-in. Evaluations must also occur quarterly and with any change of condition.

Please provide any stakeholder feedback documentation you have on the Lewin Report.
We have attached the correspondence formally submitted by the Governor's Commission on Senior Services. We have also provided a compilation of stakeholder feedback on the Lewin Report.

The Department hopes our answers to your questions were responsive and adequate. Please let us know if you have additional questions.

Sincerely,

Eric Luther Moore
DHS Chief Financial Officer

CC: Laurie Byerly, Legislative Fiscal Office
Tamara Brickman, DAS Chief Financial Office
Cathy Connolly, DAS Chief Financial Office

DHS – APD Stakeholder Listening Session March 23, 2016 regarding Budget Note HB 5026

Best Case Scenario

Program is fully funded – Caseloads grow as forecasted – Need to slowly bend the cost curve

CORE VALUE	POTENTIAL OPPORTUNITY	GREATEST ANGST
Believe in the APD Mission, Vision, and Goals	Greater collaboration between healthcare and long term services and supports	Services for high needs consumers reduced so much independence is compromised
ORS 410 and what it stands for	Get Congress to permit competition amongst Rx providers for Part D drug costs	Lack of funding for Adult Day Care Centers
Mentioned numerous times: Choice, Dignity, Independence	Ombudsman for DME, breaks down brick walls	Transportation as a barrier to using services
Person first– least restrictive – centered on needs	Innovations – especially use of technology	People will not get services they need and suffer as a result
Keep families strong through support	Dual eligible, pre-duals, and persons most at risk – care and cost (triple aim)	ACFS rising costs with providing least activity/frailty compared to AFH, RCF, in-home
Continued innovation – taking the lead	Shift focus to non-XIX (private pay or care) family caregivers	Maintaining caseload - given attrition (specifically about individuals with moderate to late stage dementia)
Person centered	Programs and services to more people across the State	DHS leadership changes, lack of stability
Move Medicaid residents from high priced nursing, assisted living and residential care facilities into adult foster homes	To serve the growing number of people diagnosed with Alzheimer's and other related dementias across the disease process, not when in crisis or in as a reaction to a dangerous situation (i.e. APS)	Due to the growing population, Seniors and people with disabilities the current funding of services can't be funded or sustained given the current delivery system
Choice; respecting choice, maximizing choice and promoting individual choice	To support care partners (givers and recipients)	Multnomah County implementing "rules" before they are yet approved
Providing equitable access	New minimum wage – more $ into State	Minimum wage changes
Preventive	General assistance expansion	ALFS growing costs with providing
Risk tolerant	Create a state with no boundaries – work together to focus on consumer	More housing – bariatric, mental health
Focus on prevention	Better use of technology	Oversight of new care
Access and well trained caregivers	PACE program expansion	Department of Labor impact, home care services program
Training and education opportunities for paid and unpaid caregivers	Expand OPI to all people with disabilities	Not innovating and addressing pre-long term services and supports and ways to helps families care
Person centered services and programs	Foreign competition with pharmaceutical companies	Staying in home is seen as too expensive – reduce choice
Interdependence	Better coordination of services	Kids vs services (pitting service streams against each other)
Do no harm	Add a 6th resident to adult foster homes	Never plan appropriately
Engagement of consumers	Universal Provider number	Lack of workforce
Evaluate and measure accountability	Pace Pilot Act – serving duals	Funding
	Better intact forms and standards	Population expansion
	Expand workforce	Oversight of new care providers

Alternate Case Scenario

Program is not fully funded – Reductions below current service level – Need to rapidly bend the cost curve

CORE VALUE	POTENTIAL OPPORTUNITY	GREATEST ANGST
Family values (you do it yourself)	Tax population	Consumer impact on those who may lose services
Choice	Forces innovation and new practices	Cost more of state budget for services
Shared sacrifice	Forces greater focus on evaluation and assessment	Mental Health first to be cut - costs more in long-term
Unemployment for homecare workers	Puts greater focus upon private pay or family caregivers	Risk of being out of compliance with state regulations
No longer set example (as a leader in long term supports)	Force Employers to see impact and help	Inability to use real data measures to evaluate and adjust for unintended consequences
Zero changes to the values, can see changes when the values are driven by a stricter bottom line	Service and assessment tools qualifications	Greater case management and caseloads, less focus on matching services to individuals and their needs (less person centered care)
People first is no longer a priority	APD lottery	Long term services and supports is forced into medical model
Remind Legislature and Governor of promise to provide 50% savings to long term services and supports	Keep track of those cut from services (discussion on the value of knowing what happens to those who are cut from services and if, as an example, they come back to a higher level of service or become sustaining with something different)	Snowball effect of cuts could lead to a recession –fewer tax revenues –more unemployment and other demands on system
Financial stewardship	(can't make it out) Sales tax	Pitting kids, schools, public safety and others vs older adults and persons with disabilities
	State funded senior companion program	Forced in-home cuts
	Better demonstration project versus K state plan	Can't carry over
	Try to find more money	Kids against senior services and people with disabilities
	Natural supports	Lack of preventative services
	PARIS –related to using Federal programs in lieu of State program when appropriate	Cut to overall programming and staff who deliver the services
	Partnering/volunteers/interns	Individuals moving to higher care needs if cut from services at a lower case level
	Look for creative ways to make services more affordable, or more accessible	Potential for reduced quality of care and services
	Focus on prevention as a cost containment strategy	People become sicker – increasing cost
	Family contribute to Medicaid care plan	Loss of services
	Technology assisted devices	More homeless
		Loss of community based services
		Staff turnover - field strain
		Penny wise – pound foolish

	Support and education around special populations (dementia, mental health)	Looking for a silver bullet – there is no such thing	DRAFT			
	Consider how to heighten or strengthen role of natural supports	Quality of care with dissemination of system				
	Ability to offer enhanced services to individuals diagnosed with intellectual, cognitive and physical disabilities	Long term services and supports may be forced more toward a medical model				
	Preventative services and programs	Unfettered housing with services				
	Innovation bring better services and more federal money	Lack of resources for prevention and early intervention				
	Quality housing with services program	Wait list for services				
	HCBS seen as a cost saver – changing the dialogue around Salem on that	Lewin Group, recommendations too severe				
	Focus on pre-Medicaid population, delay or defer	Lack of funding to support community resources				
	Stronger emphasis on prevention and early intervention	Increasing workload or field staff – unmanageable				
	Wraparound services to keep folks in-home longer; including technology supports	Federal labor rules will add non-productive costs, requiring reductions in the number of persons who can be served				
	Commitment to workforce development	Budget forecast for years 17-19				
	More, robust training and cross agency coordination	Jumping from one plan to another, no fidelity				
	Could find enhanced Medicaid Federal money through creative approaches	Quality of care will get worse instead of better				
	Better coordination of services	Sustainable funding beyond biennium				
	More support for family caregivers would delay entrances into higher levels of care or into Medicaid system	17-19 potential cuts so low that it will require significant cuts to our programs				
	Service assessment – tweaks around # of hours and type so services for IDL's and IADL's)	Not driven by evidence based outcomes				
	Navigators to help consumers through the system	Legislators with lack of knowledge of situation				
	Better waiver	Legislative intent and the budget note				
		Lack of community understanding of needs				
		Demographics – different impact for different populations (age based)				
		Lack of proper planning				
		Developing outcomes around data – data needs to show we are making a difference				

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Kate Brown, Governor

Governor's Commission on Senior Services

GCSS

Joint Committee on Ways and Means
900 Court St. NE, Room H-178
Salem OR 97301

March 11, 2016

To Members of the Joint Committee on Ways and Means:

It has come to the attention of the Governor's Commission on Senior Services that your Committee requested the Department of Human Services (DHS) to identify cost saving scenarios that would limit spending to 10% growth in the budgets of Aging and People with Disabilities (APD) and Intellectual and Developmental Disabilities (IDD). Our Commission reviewed the report recommendations in response to your request to DHS, and has a number of concerns we would like to share with you.

Choice of Consultant
We understand that there was a short time frame on this request, and that DHS issued an RFP that resulted in only two proposals. The proposal submitted by the Lewin Group, a subsidiary of UnitedHealthcare and specifically owned by Ingenix, was chosen. The Commission would like to point out that although the Lewin group has historically been viewed as a high quality consulting group, its current affiliation with health care companies should be considered in assessing the group's neutrality in terms of viewpoints and recommendations. It was pointed out by our Commission, for example, that in identifying strategies to reduce costs, reducing payments to health care providers was not an identified strategy.

Scope of Question Posed
Our understanding is that APD was asked solely to identify cost control scenarios, absent of any analysis of either human costs in physical, emotional or economic losses that scenarios could produce, and/or without consideration of the shift of costs to other systems that would be the logical result of such scenarios. An approach focused only on costs to the department - without a broader set of analyses - lacks the rigor that should be afforded to the residents of Oregon.

Viability of Scenarios Posed
As cost alone was the criteria focus for this consultation, the report lacks approaches with any real viability. For example, in the service priority level of care reduction scenario, there is the notion that service priority levels for Medicaid-eligible consumers could be cut off at level 7 or even at level 4. The levels eliminated, however, represent assistance with feeding bathing, dressing, and ambulating, activities of daily living that are crucial to many aging consumers' ability to function on a day-to-day basis. Similarly, in IDD, reducing service eligibility to those with an IQ of 70 or lower would result in a lack of assistance for those needing help with daily functioning. Even in the 70 to 79 range, it is typical for individuals to require assistance in managing daily activities and performing simple tasks. In this scenario, our state would also be reversing decades of success in assisting Oregonians who choose to remain in their own homes and communities, often at a reduced cost to the system than alternative long term care options. From a cost perspective in this scenario, there would be an increase in costs simply

shifted back to institutional care, which is the antithesis to the direction advocates and other constituents would choose to follow. Older people and people with disabilities are part of our communities, and the Commission's goal to deepen our commitment to choice and independence for these individuals, not to limit it, only to shift expenditures to nursing homes and other long term care settings.

In another scenario, involving repeal of the $500/month income allowance, the Lewin Group stated that without those funds, "Some [consumers] may have to go to nursing homes or other care settings due to a loss of $6,000 annually." This was one case in which implications were identified. The majority of scenarios in this report, however, excluded any consideration of the costs (financial, human or otherwise) that each approach would likely create. Further, although there is mention of "stakeholder response" to the scenarios in the report, no mention of how that stakeholder response was attained.

Toward the end of the report, there is a disturbing discussion about developing a managed care system that brings in a number of health care management companies as a potential solution. There is also the assertion that long term care services be managed through CCO's. Our Commission has serious concerns about turning our long term, community based care system over to any health care provider, especially given the current lack of inclusion within these systems, the absence of voice of elders, disabled individuals or their advocates, and, frankly, the silence thus far from any CCO around issues or needs of Oregon's older and/or disabled citizens.

We would like to act as a resource to your Committee on this matter, and we hope that we can have continued conversations about providing for the needs of the growing number of older and disabled adults in our state. We are aware that DHS and APD were put in a difficult position by being asked to produce a report on this matter in such a short time frame, and in no way do we offer any criticism of the manner in which they attempted to respond. We simply want you to know that we believe this matter requires much greater consideration and attention in order to ensure a sustainable level of quality care for Oregonians.

On behalf of the Governor's Commission on Senior Services, I thank you for your time and attention to this important matter. We look forward to further discussions in the coming months.

Sincerely,

Judy Strand

Judy Strand, Commission Chair