



Bending the Curve: Opportunities to Promote Sustainability in
Oregon's Long-Term Services and Support System
Draft Final Report



HEALTHCARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

Prepared for: Oregon Department of Human Services; Aging and People with Disabilities and the Office of Developmental Disabilities Services

Submitted by: The Lewin Group, Inc.

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Table of Contents

I. Executive Summary	1
Introduction	3
Study Background	3
Methodology	4
Data Sources	4
Category Grouping.....	5
Forecasting Approach	6
Study Limitations	7
Current State of Oregon’s Long-Term Care System	8
Eligibility Changes	8
K Plan implementation.....	8
Eligibility.....	9
Enrollment Limits	9
Reduction in Amount of Income Over Supplemental Security Income (SSI) Required to Contribute	10
Service limits	10
Direct Care Worker Wage Increases	12
LTSS Spending Trends	14
Aging and People with Disabilities (APD)	14
Intellectual and Developmental Disabilities (IDD)	17
Forecasts	18
Scenarios for Bending the Cost Curve	22
Changes Necessary to Bend the Cost Curve	22
Reduce the Rate of Increase or the Absolute Number of LTSS Recipients: Overview	22
Reduce the Number of or Increase in LTSS Recipients: Specific Scenarios.....	26
Reduce the Rate of Increase in Payments per Participant: Overview.....	29
Change Participant Cost-share: Repeal the In-Home Allowance.....	32
Increase Integration	34
State-administered MLTSS.....	34
Greater Integration with Coordinated Care Organizations (CCOs)	35
Contract for MLTSS	37
Leverage Technology	39
Stakeholder Feedback	41
What Stakeholders Value	41
Stakeholder Reactions to Potential Policy Changes	41

Appendices

Appendix A: Overview of Oregon’s Long-Term Care Eligibility Requirements

Appendix B: Relevant Medicaid Authorities

I. Executive Summary

As instructed by HB 5026 Budget Note, Oregon’s Department of Human Services contracted with The Lewin Group to conduct an independent study of the state’s long term services and supports (LTSS). Oregon has led the country in the use of home and community-based services as an alternative to institutional services and currently has 80 percent of Medicaid LTSS spending devoted to HCBS. Oregon’s tremendous progress means the state has limited ability to make further shifts from institutional to HCBS. This study identifies potential strategies that DHS can employ to help “bend the cost curve” to slow the rate of growth in spending and promote program sustainability.

Spending for LTSS for both Aging and People with Physical Disabilities (APD) and individuals with Intellectual and Development Disabilities (IDD) have increased significantly since Oregon’s implementation of the K Plan. In the two years prior to the K Plan, annual spending increases for HCBS averaged less than five percent for both APD and IDD. With expanded access under the K Plan, increased payments per participant due to more services allocated, higher payment rates (much of which were designated for improved direct care worker wages), and reduced cost-share requirements associated with the in-home allowance, APD spending increased 13.3 and 16.9 percent respectively from 2013-2014 and from 2014-2015, while IDD spending increased 11.9 and 19.4 percent.

In projecting expected caseloads and spending through 2025, Lewin anticipates that K Plan implementation will continue to expand caseloads and that these large increases in new users to the system will not subside until after 2020. As a result, Lewin reviewed four broad options for changing the trajectory of LTSS spending:

1. Policies affecting the number of people eligible for and accessing services
2. Policies that determine the amount and type of services individuals can access
3. Policies related to payment rates
4. Policies related to participant cost-share and mechanisms to increase the federal share of Medicaid financing

The chart below summarizes the changes necessary and the key impacts of the scenarios modeled. In addition to estimating the necessary reductions in caseload and payments per participant to achieve 10 percent spending growth per biennium, we modeled two specific scenarios that have one-time reductions in the rate of increase in spending (unless they are phased-in over time) – increasing the required functional need to receive services and repealing the \$500/month in-home allowance. We also considered several approaches that we were unable to model the financial impact. These included greater integration of primary, acute and LTSS through several options and leveraging technology.

Exhibit ES-1: Summary of Impact on Scenarios Modeled

	APD	IDD
Reduction in Caseload to Achieve 10% Biennium Spending Growth		
2023-25 Baseline Projected Caseload	45,628	22,535
2023-25 Caseload to Achieve 10% Spending Growth	39,621	19,772
Difference	-6,008	-2,763
Increasing Functional Need Requirements		
2023-25 Baseline Projected Spending	\$1,100M	NA
2023-25 Scenario Spending		
SPL 1-7	\$851M	NA
SPL 1-4	\$611M	
Difference		
SPL 1-7	-\$249M	NA
SPL 1-4	-\$489M	
Reduction in Annual Payments per Participant to Achieve 10% Biennium Spending Growth		
2023-25 Baseline Projected Annual Payments per Participant	\$42,616	\$74,668
2023-25 Annual Payments per Participant to Achieve 10% Spending Growth	\$37,005	\$65,513
Difference	-\$5,611	-\$9,155
Repeal the \$500/month In-home Allowance		
2023-25 Baseline Projected Spending	\$1,100M	NA
Additional Cost-share Collected from In-home Participants	\$1,044M	NA
Difference	-\$55M	NA

Note: Due to the tight timeline for the acquisition and processing of data and changes in data systems over the historical period of analysis, Lewin was unable to model the spending impact for two of the scenarios for IDD. Discussion of the implications of these scenarios for IDD programs is detailed in the full report.

Introduction

In response to growing caseloads and service expenditures, the Joint Committee on Ways and Means included a 2015 budget note requiring the Department of Human Services (DHS) to report on alternatives to decrease the rate of growth in long-term services and supports (LTSS) expenditures.

Study Background

Oregon, long recognized as a leader in long-term services and supports (LTSS) policy, has created a system that values choice, independence, safety, and health. As the first state in the nation to gain approval for a 1915(c) home and community-based services (HCBS) Medicaid waiver, Oregon has pioneered many innovative approaches to providing services in the community to Medicaid members who would otherwise live in an institutional setting. Today, the system has evolved to have the highest percentage of Medicaid LTSS spending on HCBS, nearly 80 percent, of any state in the country¹. Continuing the trend of innovation, Oregon became the second state to implement the Community First Choice Option under Section 2401 of the Affordable Care Act (ACA) and Section 1915(k) of the Social Security Act.² The “K Plan” allows Oregon to cover many HCBS services under the Medicaid State Plan as part of the full medical benefit rather than through 1915(c) waivers. While the state does receive additional federal matching funds on these services, it has also increased the numbers of Medicaid members able to receive LTSS because the 1915(k) authority does not permit limits on the number of individuals receiving state plan services as with the 1915(c) authority. Under the K Plan, beginning in July 2013, all Oregon Health Plan members who meet the level of care (LOC) and program eligibility criteria now have access to community-based LTSS.

In the fall of 2013, prior to the launch of the ACA’s exchanges, Oregon’s total Medicaid enrollment stood at 626,356. That number increased by 450,400 people as of July 2015 – a 77 percent increase³ -- some of whom meet the level of care criteria for K Plan services. In response to growing caseloads and service expenditures, the Joint Committee on Ways and Means included a budget note requiring the Department of Human Services (DHS) to report on ways to decrease the rate of growth in LTSS expenditures.

¹ Steve Eiken, Kate Sredl, Brian Burwell, and Paul Saucier (2015) *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013: Home and Community-Based Services were a Majority of LTSS Spending* accessed at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>

² See **Appendix B** for high level descriptions of the various Medicaid authorities.

³ Oregon Health Plan website accessed at http://www.oregon.gov/oha/healthplan/pages/about_us.aspx.

“The Department of Human Services is directed to report to the Joint Committee on Ways and Means during the 2016 legislative session on ways to ensure services to older adults and people with disabilities and people with intellectual and developmental disabilities remain sustainable into the future with a goal of capping biennial general fund budget growth at ten percent. Issues explored should include, but are not limited to, service eligibility, income eligibility criteria, and service array or level of services offered. For identified options, the report will cover associated fiscal impacts, potential implementation timelines, state law or rule changes required, experiences from or comparisons to other states, and the likelihood of obtaining any needed federal authorization.”

HB 5026 Budget Note, 2015 Oregon Legislative Session

DHS contracted with The Lewin Group to conduct an independent study in response to the HB 5026 Budget Note. Lewin realizes that Oregon faces a real challenge to stay within the proposed ten percent growth rate general fund budget cap as caseloads and service use increases. Since the state has already been so successful in rebalancing the long-term care system to shift care to more cost effective community-based settings, it will not have as many opportunities available to contain costs as other states. This study identifies potential strategies that DHS can employ to help “bend the cost curve” to slow the rate of growth in spending and promote program sustainability.

Methodology

The scope of the analysis for this report includes Medicaid home and community based waiver, state K Plan, and nursing facility services for adults and children, including those dually eligible for Medicare and Medicaid services. The State provided data files for Aging and People with Disabilities (APD) and Intellectual and Developmental Disabilities (IDD) populations. Data for PACE program enrollees were also provided. The data provided included Service Priority Levels for individuals receiving home and community based APD services.

Lewin transformed the data provided by the state into Per Member Per Month (PMPM) enrollment and expenditures, grouped into service categories to facilitate analysis and modeled to project caseloads and expenditures based on policy recommendations. Each of these steps is discussed further in the sections below.

Data Sources

Lewin manipulated the raw data files provided by the state using SAS programs to merge the member eligibility file with the claims file. First, the files were converted to ensure that each row captured information on one month only. For example, if an eligibility record had a three month span May through July, it would be duplicated into three rows: one each for May, June and July. Subsequently, member eligibility and claims were merged by Member ID and month, so if a claim was dated June 2013, it would only be matched if the same person had eligibility in June 2013. Expenditure data for IDD Children’s Intensive In-Home services did not reflect complete spending data due to claims entry lags. As a result, we excluded these services from the analysis.

This does not have a material impact on the analysis because they represent a small portion of the total program spending.

Category Grouping

The data in the claims file contained several categories which were grouped as outlined in **Exhibits 1** and **2**. All of the IDD analyses only include individuals who received one of the services listed in **Exhibit 2**.

Exhibit 1: APD Data Categories

In-home
Community Based Residential
Nursing Facility

Exhibit 2: IDD Data Categories

Adult – Comprehensive In-home Services
Adult Long-Term Supports
Adult – 24-Hour Residential
Residential Facilities
Adult – Brokerage Enrollment
Local Authority Claims
Adult – Non-Relative Foster Care
Non-Relative Foster Care
Stabilization and Crisis Unit
State-Operated Community Program
Adult – Supported Living
Supported Living
Children – Children’s Intensive In-home Services
Children’s Intensive In-home Services
Children - In-home Supports
Children’s Long-Term In-home Supports
Children – Children’s Residential
Children’s Residential
Other DD - Employment
Employment
Other DD – Family Support
Family Support
Other DD – Transportation
Transportation

Forecasting Approach

Lewin generated baseline forecasts for enrollment and PMPM using Tableau data visualization software. In general, for APD and IDD programs, the forecast model used was “Automatic without Seasonality” which applies Time Series Forecasting with trend and no seasonality.⁴

For IDD categories where the “Automatic without Seasonality” model did not generate optimal forecasts due to fluctuations in data, we used a “Custom with no trend and no seasonality” forecast model which applies Time Series Forecasting with no trend or seasonality.

For APD Community Based Care (CBC) and In-home categories, we used historical data starting in SFY 2008 for the forecasts. For APD Nursing Facilities, we used historical data from SFY 2012 onwards. For IDD analyses, we used historical data from SFY 2011.

Tableau projections provided upper and lower bound projections based on a 95% confidence interval. Based on the State’s caseload forecast, we applied either the upper bound or constant projections from Tableau⁵. The baseline time series projections were adjusted to smooth trend outliers that may have resulted from the underlying data issues and the numerous policy changes and provider rate increases implemented in Oregon over the study period. The projections were modeled for each policy scenario individually to allow the state to understand the implications of each option. If multiple policy scenarios are implemented, the results may vary.

Financial projection calculations for APD and IDD applied the following Federal and State shares:

- Federal Share (70.38% which reflect FMAP of 64.38% + the enhanced match of 6% for the K Plan) and State Share (29.62%) – except for APD nursing facilities.
- APD – Nursing facilities - Federal Share: 64.38% - State Share: 24% to account for the provider tax funds
- 1915(c) Services (e.g., employment and vehicle modifications) -- Federal Share: 64.38% - State Share:35.62%
- Family Support – 100% state general revenue.

⁴ Seasonality reflects changes that have a pattern over the course of the year (e.g., higher hospital admissions in the winter due to flu and pneumonia). LTSS caseloads did not show any seasonal patterns.

⁵ Fall 2015 DHS/OHA Caseload Forecast, retrieved online January 28, 2016 at <http://www.oregon.gov/DHS/BUSINESS-SERVICES/OFRA/ofradocuments/Fall%202015%20Caseload%20Forecast.pdf>.

Study Limitations

Lewin conducted this study in a very short timeframe which limited our ability to pursue all potential strategies for bending the cost curve and their impact. The timeframe did not allow the pursuit of acute and primary care, as well as pharmacy and income data. Lack of primary and acute care costs meant potential savings on these costs generated by HCBS services could not be modeled. Lewin used income data for individuals with disabilities in Oregon from the American Community Survey as a proxy to develop assumptions for the in-home allowance repeal scenario.

The timeframe set for the historical data analysis for the Lewin report covered a significant change in billing and claims processing for the IDD service system. Specifically, the introduction of the Plan of Care/eXPRS system for authorization and billing of most DD services, including in-home supports for children and adults. This switch from the past payment system to the current system created differences in data labels and tracking expenditures by service type. The Office of Developmental Disabilities Services (ODDS) data team worked with Lewin to clarify and quality check the data used for the analysis in the report. This effort took considerable time and effort, more than initially anticipated, and ultimately resulted in not being able to examine service authorization data for IDD participants.

ODDS was also not able to provide IDD level of care data for the IDD population due to the significant data collection effort that Counties that perform IDD eligibility functions would have had to undertake. Even if the state had been able to provide assessment data, the ODDS assessment does not result in a similar service level proxy for functional level/acuity as for APD, so would have been of limited use for modeling. Finally, the state was also unable to provide MDS data for nursing facility residents because it would have required obtaining permission from CMS to share the data; a time consuming process that the project timeframe did not permit. This limited our ability to compare acuity between individuals in nursing facilities and those receiving home and community-based services. Even with the data challenges noted above, Lewin received sufficient data to ensure the analysis resulted in accurate/appropriate examination of alternative scenarios within the timeframe required.

Current State of Oregon's Long-Term Care System

The implementation of the K Plan has received much attention. The K Plan uses the same eligibility criteria as the prior 1915(c) waivers' institutional level of care. It provides supports for individuals who need assistance with activities of daily living, instrumental activities of daily living and health related tasks. Additional services, such as employment supports, are provided through the 1915(c) waivers. In addition to the K Plan, Oregon has implemented other changes in recent years with varying impacts on enrollment and expenditures. The following section discusses these changes, including Medicaid eligibility as a result of the ACA mandates and direct support worker wage increases.

Eligibility Changes

There have been minor eligibility changes/amendments to Oregon Medicaid waivers over the past several years. In 2013 and 2014, Oregon instituted additional eligibility changes related to residency, citizenship, presumptive eligibility conducted by hospitals, and the use of Modified Adjusted Gross Income (MAGI) eligibility groups. MAGI is a simplified income standard used to determine Medicaid eligibility for children, parents, pregnant women and adults under the Medicaid expansion group. Although Oregon adopted MAGI, individuals aged 65 and older and those who qualify for Medicaid based on disability still have asset tests applied to determine financial eligibility for LTSS. A summary of the eligibility standards used by DHS is provided in **Appendix A**.

K Plan implementation

CMS approved Oregon's State Plan Amendment (SPA) to include the Community First Choice (CFC) State Plan Option (K Plan) on June 27, 2013 and it became effective on July 1, 2013. This SPA to adopt the K Plan was designed to:

- Reinvest increased revenue from FMAP to support the expansion of less-costly and more preferred home and community-based services;
- Support more individuals to remain at home in their community of choice.

Services allowed under the K Plan program include attendant services to assist with Activities of Daily Living (ADL's), Instrumental Activities of Daily Living (IADLs), and health-related tasks. These services and supports include hands-on assistance, cueing and supervision. The scope of services available to K Plan participants is based on an individualized functional assessment of service needs and must be unmet by other paid or unpaid resources. In addition to the required K Plan services, Oregon opted to cover expenditures for transition costs, such as initial rent, utilities and home items needed for individuals moving from an institution to a community setting. Additionally, certain expenditures that substitute for human assistance, such as environmental modifications, assistive devices, and community transportation, are also covered.

Eligibility

Eligibility for K Plan services follows institutional level of care – nursing facility, ICF/ID or hospital:

- **Nursing Facility Level of Care or NF LOC** -- based upon the Client Assessment and Planning System (CAPS) comprehensive assessment. Individuals must meet one of the 13 service priority levels as defined in OAR 411-015-0010 and have countable income below 150 percent of the federal poverty level if their eligibility group does not cover nursing facility services. Children being assessed for NF LOC must meet the priority levels as defined in OAR 411-015- 0010 in addition to a clinical criterion score of 100 or higher.
- **ICF/ID Level of Care** -- an individual must meet eligibility criteria as described in OAR 411-320-0080 for intellectual disability or developmental disability other than intellectual disability and have significant impairment in adaptive behavior.
- **Hospital Level of Care** – an individual is assessed using the tools for nursing facility and ICF/ID LOC along with additional clinical criteria. The clinical criteria tool assesses a variety of care needs anticipated to last 6 months or longer. A physician's signature is required.

For children, the state does not consider parental income for eligibility for 1915(c) waivers, which opens access to K Plan services. The treatment of a parent's income remains the same as for the pre-K children's waivers. Specifically, when family income levels become a barrier to needed services, a child can be declared eligible for Medicaid services by the Presumptive Medicaid Disability Determination Team (PMDDT) by deeming the child a "household of one" so only the child's income will be used to determine eligibility.

Enrollment Limits

Unlike 1915(c) waivers, the K Plan does not allow for enrollment limits. While many states use enrollment limits under the 1915(c) authority, Oregon, with the exception of children, has not had limits since 2000. Although the APD 1915(c) waivers have enrollment limits, historically, these have been set high enough that Oregon has not reached those limits and, therefore, has not had waiting lists. For IDD, the settlement in response to the Staley et al. v. Kitzhaber et al. lawsuit effectively eliminated wait lists for adults. Prior to the K Plan, the three children's waivers - Medically Involved, Medically Fragile (Hospital), Behavioral (ICD/IDD) – had enrollment limits of 200 or less. In addition, 140 children with IDD lived in children's group homes.

Reduction in Amount of Income Over Supplemental Security Income (SSI) Required to Contribute

House Bill 5529-A (2013) through Package 812 (State Plan K Option) built in required and ongoing maintenance of effort expenditures predicated on an additional 6% FMAP (Federal Medical Assistance Percentage) for services provided by Aging and People with Disabilities and Developmental Disabilities programs.⁶

Funds from the increased federal match were, in part, to be used to increase the in-home housing allowance to support consumers being served in their own homes, effectively giving consumers more resources to cover their non-service expenses such as mortgage/rent, utilities, food, personal needs, etc. Prior to 2014, consumers receiving APD services were required to contribute 100% of their income above the Supplemental Security Income limit (\$733/month in 2015) towards the cost of services.⁷

In direct support of the legislation, in 2014, APD increased the in-home allowance up to \$500 above the SSI limit (currently \$1,233/month). This change allows consumers to retain a higher portion of their income to remain in their own homes, but impacts the overall APD program budget as a result of the reduction in service contributions from program participants. Currently, ODDS does not collect cost-share.

Service limits

The amount of services is based on the individualized functional assessment and, unlike under the programs operated prior to the K Plan, there is no ceiling on the total dollar amount of services an individual may receive. Limits to the scope of services available to K Plan participants include the following:

Services	Limits
Home-delivered meals, chore services, community nursing services, personal emergency response systems, relief care providers, and environmental accessibility adaptations	Not allowed when individuals are receiving K Plan services in a residential CBC setting.
In-home	Limited to a need or needs, identified through the functional assessment and reflected in the person-centered plan.
Electronic back-up systems, mechanisms and any specialized or durable medical equipment necessary to support the individual's health or well-being	Limited to items approved in the services plan and are not to exceed \$5,000 and payable only when other funding authorities such as Medicare, Medicaid or private insurance, disallow the item or service.

⁶ 77th Oregon Legislative Assembly, 2013 Session, Budget Report and Measure Summary SB5529-A.

⁷ Oregon DHS Fact Sheet on APD Caseload/Cost Drivers: \$500 In-Home Allowance.

Services	Limits
Transition services	Limited to moving and move-in costs including; movers, cleaning and security deposits, payment for background/credit check (related to housing), initial deposits for heating, lighting and phone; and payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishing (i.e. bed) and other items necessary to re-establish a home. Individuals will be able to access the benefit no more than twice annually though basic household furnishing and other items will be limited to one time per year.
Environmental modifications	Limited to \$5,000 per modification
Health related tasks	Limited medical need or needs, identified through the functional assessment and reflected in the person-centered plan.

Exceptions to limits and services may be requested by the person-centered coordinator and reviewed on a case by case basis based on standards outlined in the State Plan Amendment.

Natural supports 42 CFR 441.540 Subpart K—The Community First Choice Option states that the Person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under Community First Choice, the plan must:

- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. *Natural supports cannot supplant needed paid services unless the natural supports are unpaid supports that are provided voluntarily to the individual in lieu of an attendant.*”

According to Oregon’s CFC State Plan Amendment, “Natural supports are determined to be available when an individual is willing to voluntarily provide the identified services and the service recipient is willing to accept services from the natural support. If the natural support is unwilling or unable to provide the identified services, paid supports will be provided. Nothing in the natural support determination prevents the Department from paying qualified family members who are performing paid work. The state will not provide services or supports that are within the range of activities that a parent/legally responsible individual would ordinarily perform on behalf of a child without a disability or chronic illness of the same age.”

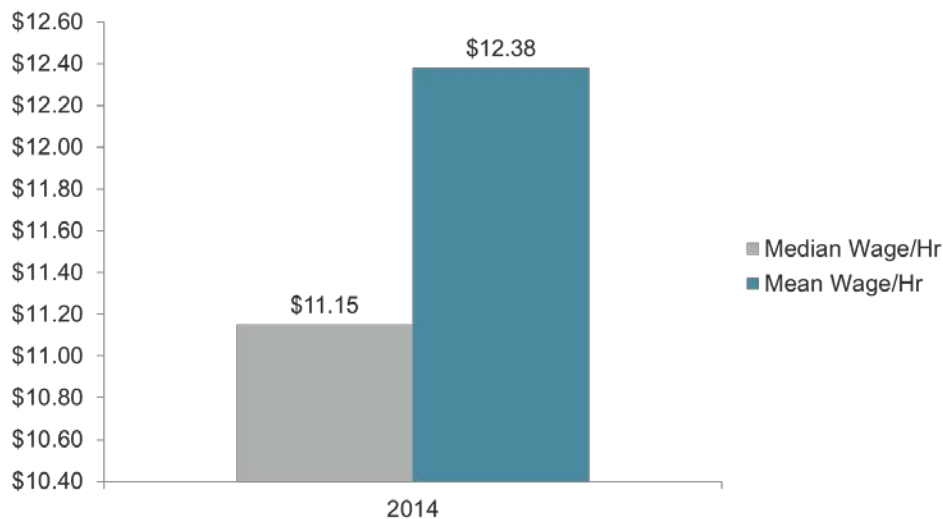
DHS has concerns over the impact of the CMS requirements for natural supports on the APD and DD programs primarily due to the potential shift to paid services from the historical and often preferred informal or natural supports. Individuals who had played important roles in consumers’ lives as informal and unpaid caregivers are now becoming paid caregivers. Stakeholders and advocates expressed concern that this may change the caregiver-consumer

relationship, and potentially isolate the consumer from the community with too much reliance on paid supports.⁸

Direct Care Worker Wage Increases

Recent direct care worker wage increases have contributed to the growth of LTSS spending. House Bill 5529, per the Budget Note on Direct Care Workers in HB5029, required the Oregon Department of Human Services to provide a report to the Joint Committee on Ways and Means during the 2015 Legislative session. The report focused on services, providers, and rates for each agency relying on direct care workers for service delivery. **Exhibit 3** shows the mean and median average hourly wages for direct care workers in 2014.

Exhibit 3: Oregon Mean and Median Wages for Direct Care Workers in Oregon, 2014



Source: RTI International analysis of the 2014 Oregon Wage and Fringe Benefit Survey of Long-Term Care (LTC) Providers.

The report included information about how wages are determined, as well as alternatives to increasing wages outside of straight rate increases. The Joint Committee on Ways and Means wanted to ensure that wage and salary increases helped reduce staff turnover.⁹ The report found that while direct care worker wages have increased from 2003–2014, they have not increased at the rate of inflation, and have increased less than provider Medicaid rate increases. However, wage increases over the 2010 to 2015 period have kept up with inflation and collectively bargained wage increases have been greater than inflation.

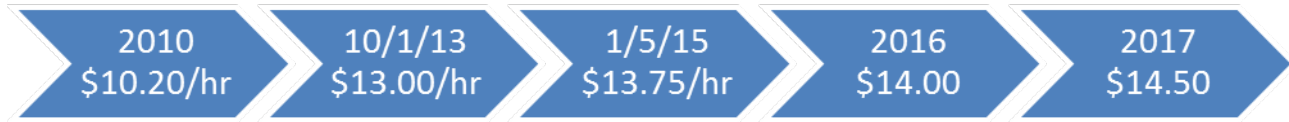
Historically, wage increases have been very minimal. According to the 2013-2015 Collective Bargaining Agreement, the Homecare Workers and Personal Support Worker wages have progressed per the contractual agreement between DHS and Services Employees International

⁸ Oregon DHS Fact Sheet on APD Caseload/Cost Drivers: Natural Supports.

⁹ Letter from the Director of Human Services to the Oregon Legislature providing an update on the Department’s implementation of the wage study per House Bill 5529.

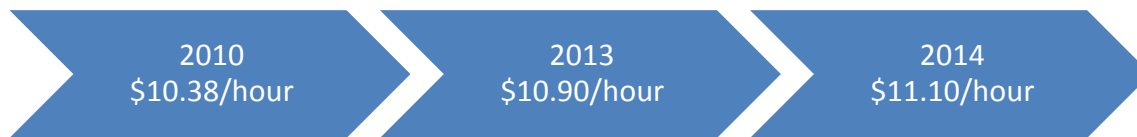
Union (SEIU) with no increases from 2010 to 2012 and a large increase in 2013 (34.8% or a 6.1% annualized increase between 2010 and 2015). Direct care workers employed by private agencies, including Certified Nurse Assistants, home health aides and personal care aides, are not included in collective bargaining agreements.

Exhibit 4: Collective Bargain Hourly Wages



For direct care workers employed by private agencies, wages have increased over the years, but not at the rate of workers protected by collective bargaining agreements. The increases below are reported average hourly wages (weighted by number of direct care workers) and equate to an annualized 1.7% increase.¹⁰

Exhibit 5: Direct Care Worker Hourly Wages



During the 2015 legislative session, the Budget Note below indicates that the DD provider rate increase that went into effect on 1/1/16 should result in a four percent increase in direct care staff wages and/or benefits during the 2015-17 biennium.

It is the intent of the Legislature that \$26.7 million total funds in provider rate increases approved in House Bill 5026 (budget bill for the Department of Human Services) result in wage increases for direct care staff serving people with intellectual and developmental disabilities (IDD). The legislative expectation is that compensation (wages and/or benefits) for direct care staff in programs serving people with IDD should be increased by at least 4% during the 2015-17 biennium. During the 2016 legislative session, an informational hearing will be scheduled for IDD community providers to present the actions they have taken or plan to take to meet budget note requirements. On a parallel track and prior to seeking an allocation from the special purpose appropriation, the Department of Human Services will compile information on any complaints received regarding wage increases and consult with legal counsel and contract staff to determine the best, yet most cost-effective, approach to address potential provider noncompliance. The Department will also report to the Joint Committee on Ways and Means during the 2017 legislative session on activity related to and progress made under this budget note.

Budget Note HB 5026, 2015 Oregon Legislative Session

¹⁰ Sara Zuckerbraun, et. al. (2015) Wages, Fringe Benefits, and Turnover for Direct Care Workers Working for Long-Term Care Providers in Oregon accessed at <http://www.oregon.gov/dhs/aboutdhs/dhsbudget/20152017%20Budget/Oregon%20Final%20Direct%20Care%20Wage%20Report%20to%20DHS.pdf>.

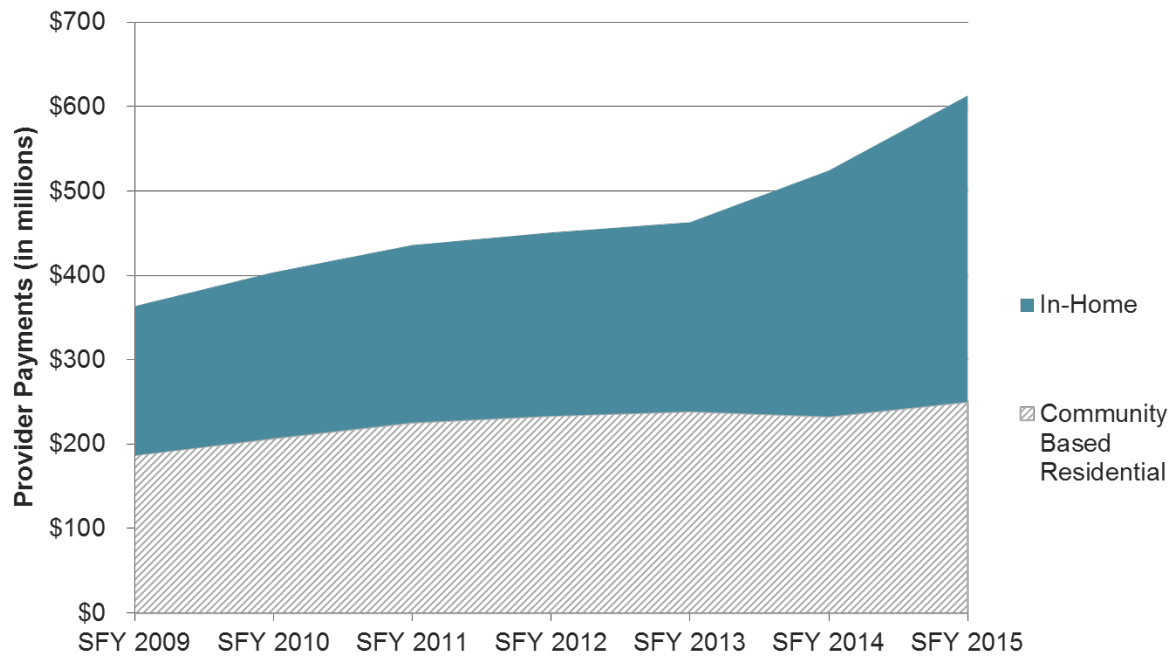
LTSS Spending Trends

Both APD and IDD have experienced significant increases in spending for in-home services since the implementation of the K Plan in 2013.

Aging and People with Disabilities (APD)

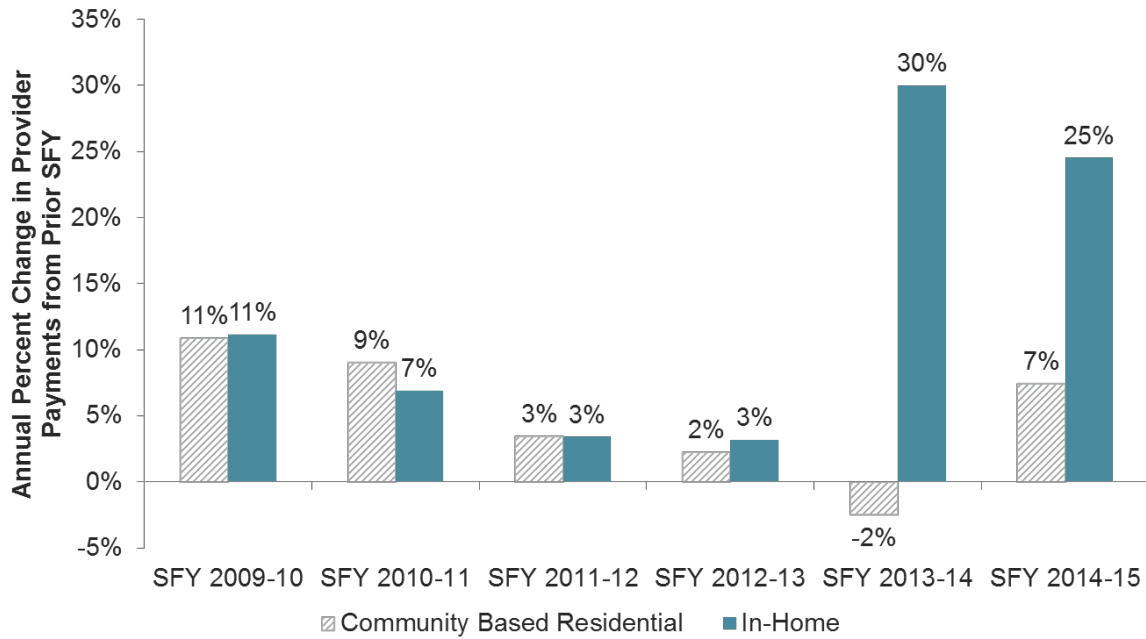
APD HCBS spending increased 70% from SFY 2009 to SFY 2015. In-home services accounted for much of the increase.

Exhibit 6: APD Home and Community-based Expenditures, State Fiscal Year 2009-2015



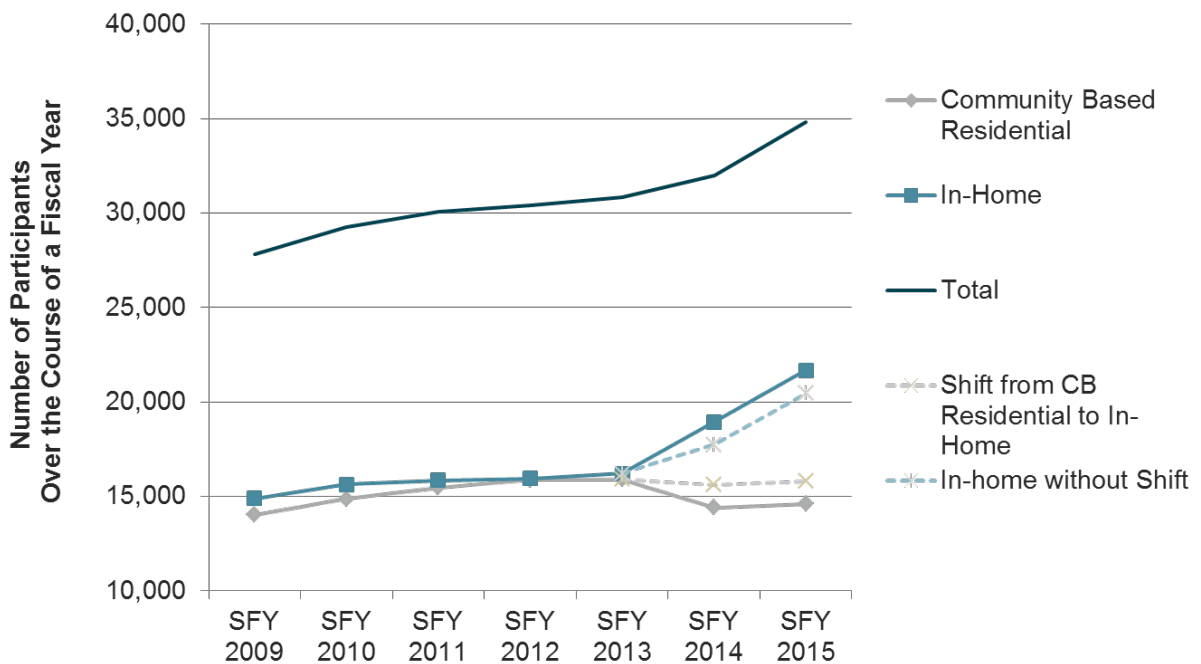
APD spending for HCBS grew significantly since K Plan implementation. Year over year in-home service expenditures increased 30% and 25%, between SFY 2013-14 and SFY 2014-15 respectively.

Exhibit 7: APD Change in Expenditures for Community Based Residential and In-Home Services, State Fiscal Year 2009-2015



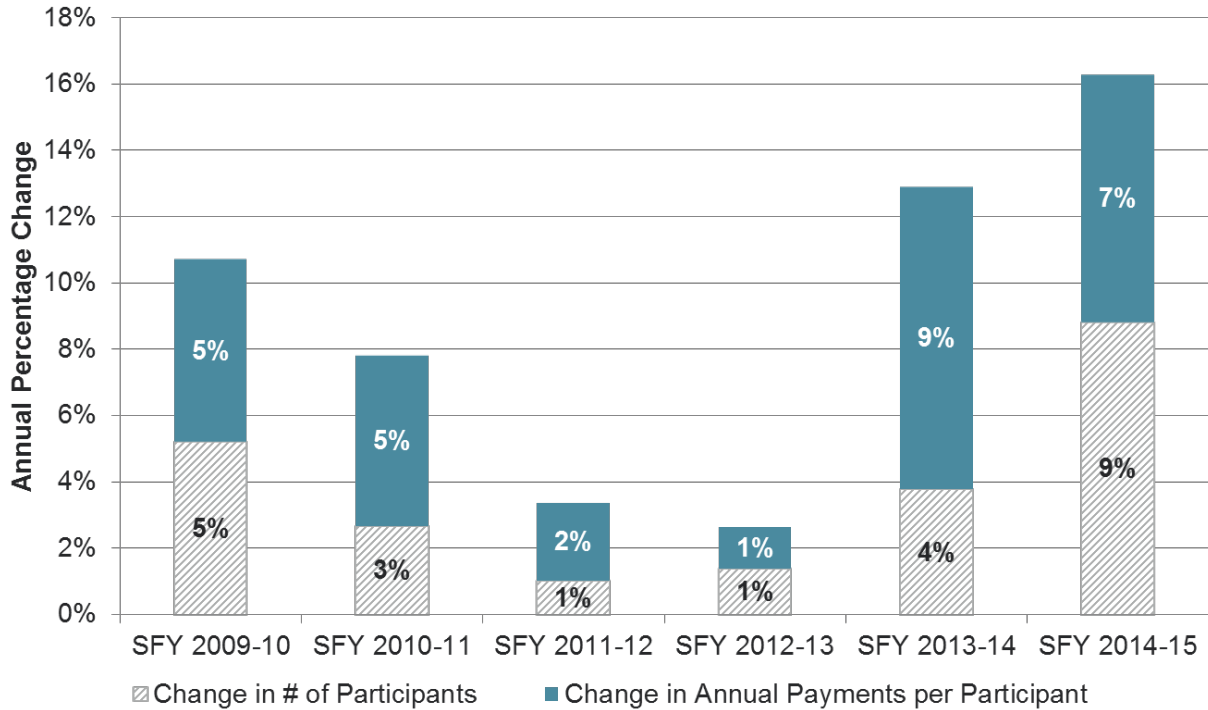
Increases in users drive a portion of the recent APD spending increase. In particular, increases in users of in-home services. A portion of the in-home user increase results from from approximately 1,200 individuals, formerly receiving services from the relative foster care program under community-based residential, moving into the in-home program at the start of the K Plan.

Exhibit 8: APD Home and Community-based Users, State Fiscal Year 2009-2015



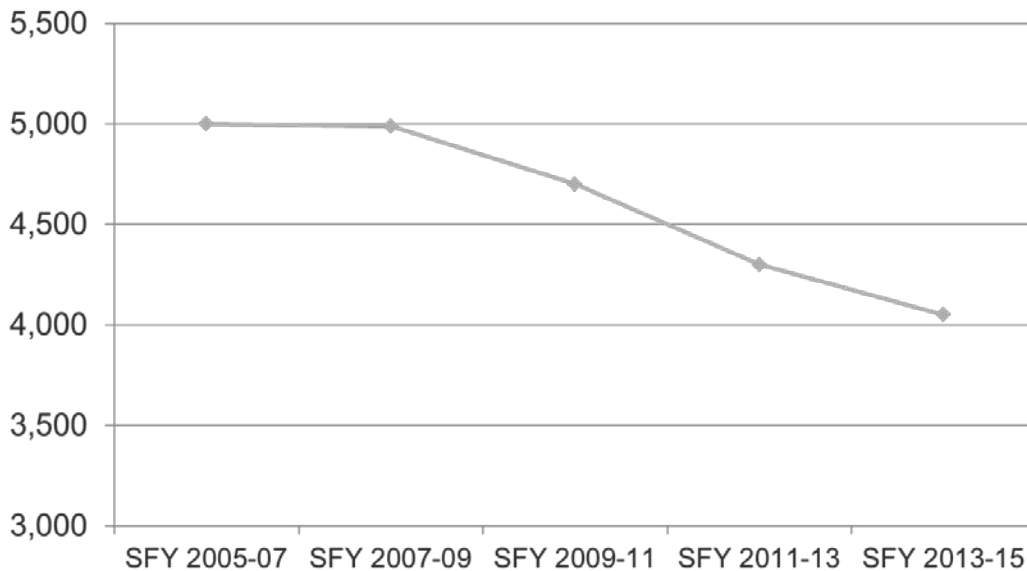
APD HCBS spending per participant also increased since the start of the K Plan. The payments per participant for APD increased 9% between SFY 2013-14 and another 7% between SFY 2014-15.

Exhibit 9: Components of APD HCBS Expenditure Change, State Fiscal Year 2009-2015



Nursing facility caseloads continue to decline and somewhat offset the increased spending on HCBS. However, unless nursing facilities close, the fixed costs associated with facilities dampen the potential decline in spending associated with fewer nursing home residents.

Exhibit 10: Average Monthly Medicaid Nursing Facility Users, SFY2005 to SFY 2015



Intellectual and Developmental Disabilities (IDD)

Recent trends in IDD payments per participant and participants (excluding case management only) are increasing. Both children and adults have increased by approximately 2,500 participants. However, with only around 1,000 children prior to 2014, the rate of growth among children is much greater than for adults (over 200 percent compared to around 20 percent).

Exhibit 11: IDD Home and Community-based Users and Annual Payment/Participant Trends (Excluding Case Management Only), State Fiscal Year 2011-2015

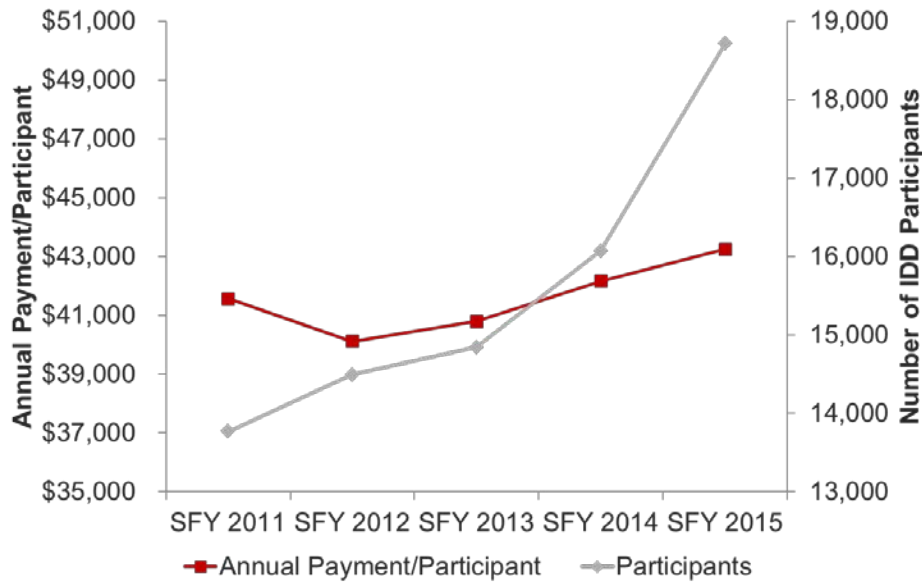
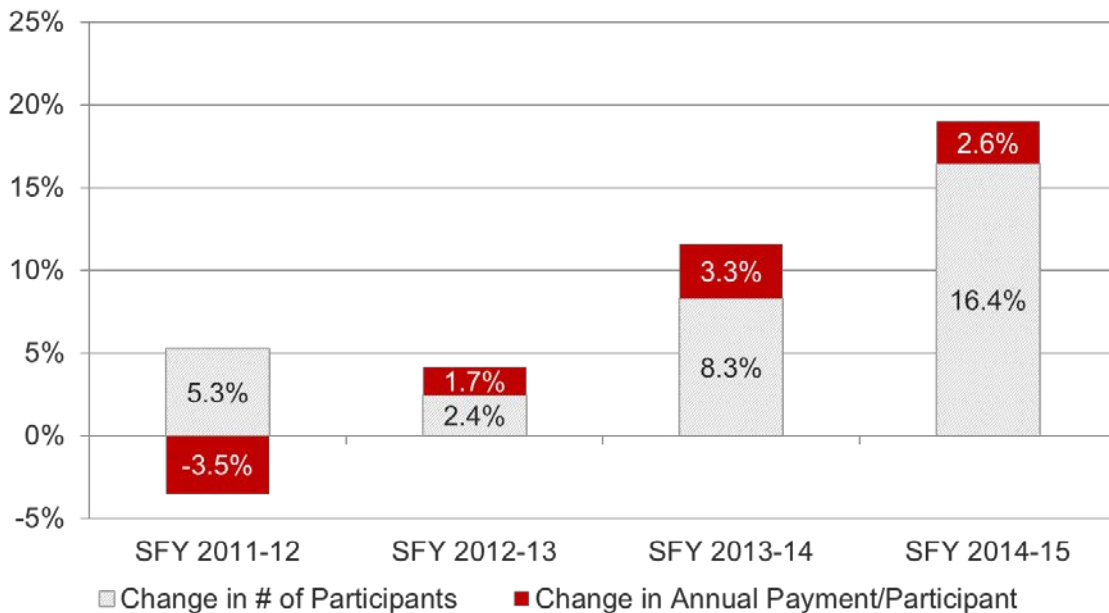


Exhibit 12 shows that caseloads have primarily driven IDD expenditure growth.

Exhibit 12: Components of IDD HCBS Expenditure Change (Excluding Case Management Only), State Fiscal Year 2011-2015



Forecasts

In order to estimate the impact of alternative scenarios, Lewin projected caseloads and spending per participants for APD and IDD shown below. Lewin’s projections for payments per participant for both APD and IDD do not account for the new Department of Labor (DOL) Fair Labor Standards Act (FLSA) regulations effective January 2016 which will likely result in higher payments per participant. For IDD, the projections do not include children’s intensive in-home services and case management only. They also do not account for anticipated growth in employment services due to the recently finalized Lane settlement agreement.

Lewin projects that the increased caseloads coupled with wage and rate increases will result in continued LTSS spending growth in excess of 10 percent biennium.

Exhibit 13: APD Projected Caseloads

Biennium	Community Based Residential Care		In-Home Non Residential Care		Nursing Facility
	Age <65	Age 65+	Age <65	Age 65+	All
2015-17	2,029	8,917	9,091	9,921	3,939
2017-19	2,070	9,271	10,334	11,876	3,876
2019-21	2,111	9,638	10,896	13,831	3,831
2021-23	2,154	10,020	11,253	15,787	3,795
2023-25	2,197	10,418	11,507	17,742	3,765

Exhibit 14: APD Projected Expenditures (in millions)

Biennium	Community Based Residential Care		In-Home Non Residential Care		Nursing Facility	Total Fund	Federal Share	State Share	% Change State Share
	Age <65	Age 65+	Age <65	Age 65+	All				
2015-17	\$120.0	\$424.2	\$449.7	\$492.3	\$820.4	\$2,306.5	\$1,574.1	\$637.1	21.3%
2017-19	\$132.0	\$475.5	\$587.9	\$677.9	\$839.8	\$2,713.0	\$1,859.0	\$756.4	18.7%
2019-21	\$144.4	\$530.1	\$690.1	\$879.0	\$863.7	\$3,107.3	\$2,135.1	\$871.9	15.3%
2021-23	\$157.3	\$588.4	\$777.9	\$1,094.9	\$890.0	\$3,508.6	\$2,415.9	\$989.2	13.5%
2023-25	\$170.6	\$650.4	\$844.0	\$1,305.4	\$918.6	\$3,889.0	\$2,682.0	\$1,100.3	11.2%

Exhibit 15: IDD Projected Caseload

Biennium	Adults				All	
	Brokerage Enrollment	24-Hour Residential Care	Supported Living	Comp In-Home Services	IDD Foster Care	Stabilization & Crisis Unit
2015-17	7,596	2,798	714	1,364	3,159	104
2017-19	7,769	2,907	728	1,732	3,213	104
2019-21	7,805	3,015	743	1,977	3,286	104
2021-23	7,805	3,124	758	2,112	3,359	104
2023-25	7,805	3,233	773	2,200	3,431	104

Biennium	Children		Others	
	In-Home Support for Children	Children Residential Care	Employment ¹¹ & Day Support Activities	Transportation
2015-17	2,842	164	4,227	3,408
2017-19	3,761	164	4,312	3,470
2019-21	4,307	164	4,399	3,531
2021-23	4,632	164	4,487	3,596
2023-25	4,825	164	4,578	3,661

¹¹ As a result of the recently settled Lane lawsuit, over the next seven years, Oregon will ensure that at least 4,900 youth with IDD ages 14 to 24 years of age are provided the employment services necessary for them to prepare for, choose, get, and keep integrated employment.

Exhibit 16: IDD Projected Expenditures Excluding Case Management Only (in millions)

Biennial	Total Fund	Federal Share	State Share	State Share % Change from Prior Year
2015-17	\$2,017	\$1,412	\$605	35.1%
2017-19	\$2,412	\$1,689	\$723	19.4%
2019-21	\$2,751	\$1,927	\$824	13.9%
2021-23	\$3,081	\$2,159	\$922	12.0%
2023-25	\$3,365	\$2,358	\$1,007	9.2%

Scenarios for Bending the Cost Curve

Changes Necessary to Bend the Cost Curve

Any state wishing to change the trajectory of LTSS spending has four general levers with which to influence the rate of increase:

1. Policies affecting the number of people eligible for and accessing services
2. Policies that determine the amount and type of services individuals can access
3. Policies related to payment rates
4. Policies related to participant cost-share and mechanisms to increase the federal share of Medicaid financing

Below, Lewin outlines the changes necessary in these levers in order for LTSS spending to remain within a 10 percent biennial increase. We also modeled and review the impact of two specific scenarios – one related to the number of people eligible and one related to the participant cost-share.

Reduce the Rate of Increase or the Absolute Number of LTSS Recipients: Overview

In order to understand the magnitude of needed changes in order for LTSS spending to remain within a 10 percent biennial increase, Lewin first examined the needed change in the number of people served.

Exhibit 17 shows the projected increase in the state APD spending for LTSS and the projected caseload from SFY 2015 to SFY 2025. Over the period, biennial increases in caseload range from 10 percent in the near term to six percent by 2023-2025, while spending increases range from nearly 19 percent to 11.3 percent. The high rate of increase in the near term results from assumptions that the full impact of the K Plan has not yet been fully realized in terms of number of users or the amount of services per user, as well as specified increases in payment rates.

Exhibit 17: Projected APD Caseload and State Spending, State Fiscal Year 2015-2025

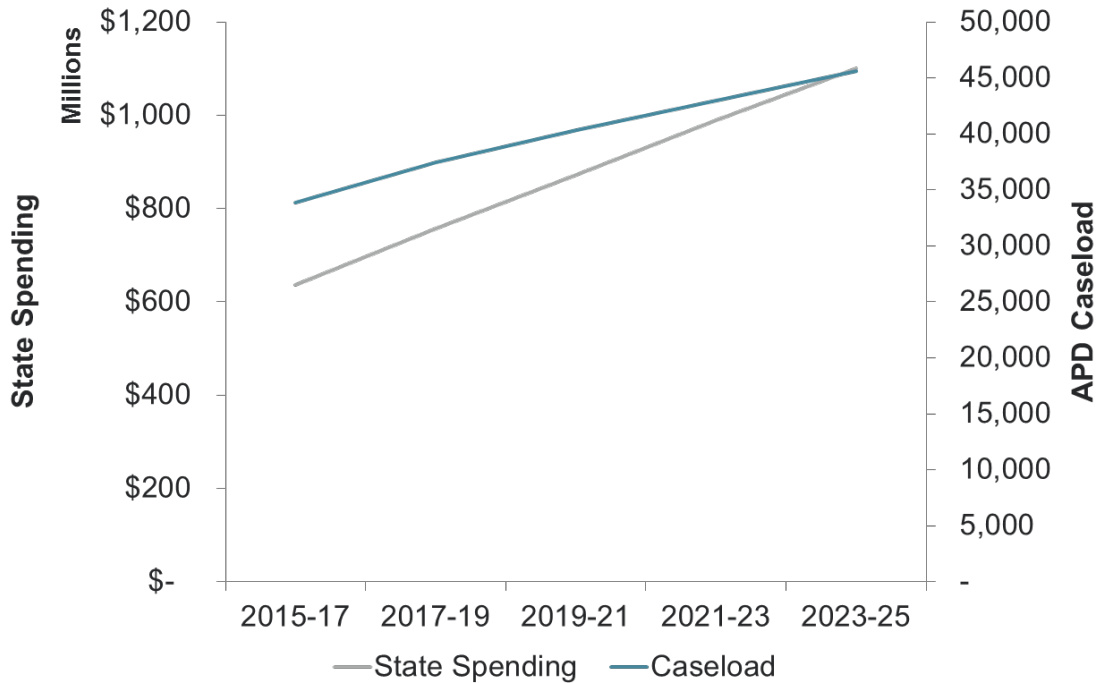


Exhibit 18 shows the necessary change in the number of APD LTSS participants to reduce state spending increases to 10 percent per biennium. In the 2023-25 period, there would need to be nearly 6,000 fewer participants. This translates into a 15 percent increase over the period rather than a 33 percent increase, approximately one-half the projected increase in the caseload and only 1.4 percent annually. With the age 65 and over population increasing between three and four percent annually during the same period, this may be difficult to achieve without major eligibility changes.

Exhibit 18: Projected APD Caseload Needed to Meet 10% Biennial Increase, State Fiscal Year 2015-2025

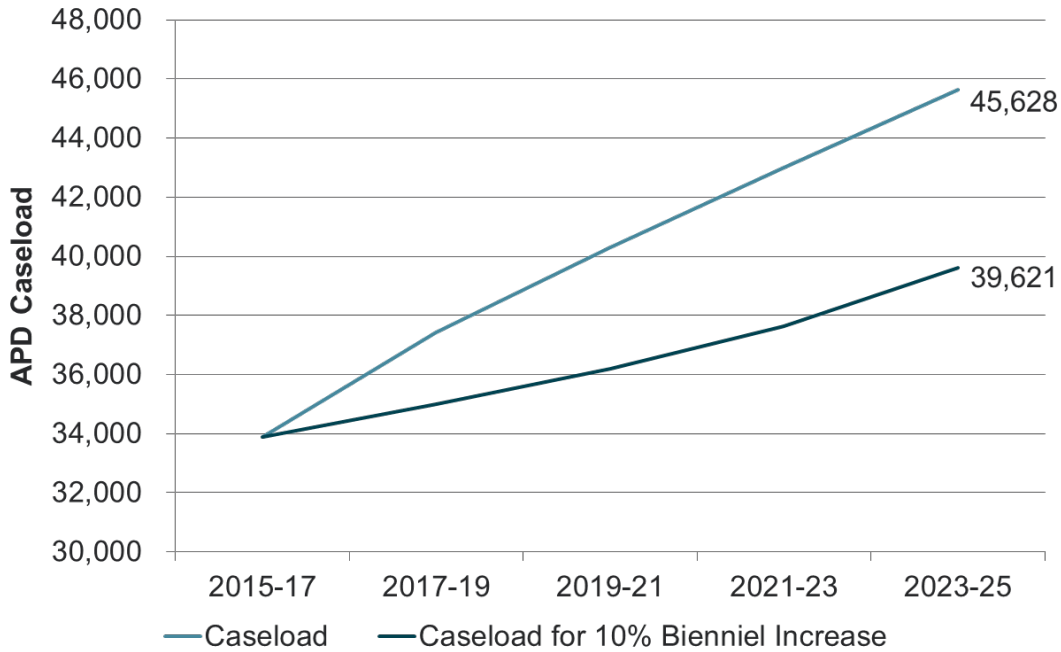


Exhibit 19 shows the projected increase in the state IDD spending for LTSS (excluding case management only) and the projected caseload from SFY 2015 to SFY 2025. Over the period, biennial increases in caseload range from 8.7 percent in the near term to 2.2 percent by 2023-2025, while spending increases range from 19.4 percent to 9.2 percent. Similar to the APD projections, the high near term increase results from assumptions that the full impact of the K Plan has not yet been fully realized. However, unlike APD, the growth in the population under age 65, which constitute the vast majority of IDD service users, is less than one percent annually over the projection period. As a result, once the one-time eligibility shock of the K Plan subsides -- where Lewin estimates an expected increase in IDD in-home users of nearly 2,700 between SFY 2015 and SFY 2020 -- caseloads should become less of a driver of state spending increases beyond 2020.

Exhibit 19: Projected IDD Caseload and State Spending (Excluding Case Management Only), State Fiscal Year 2015-2025

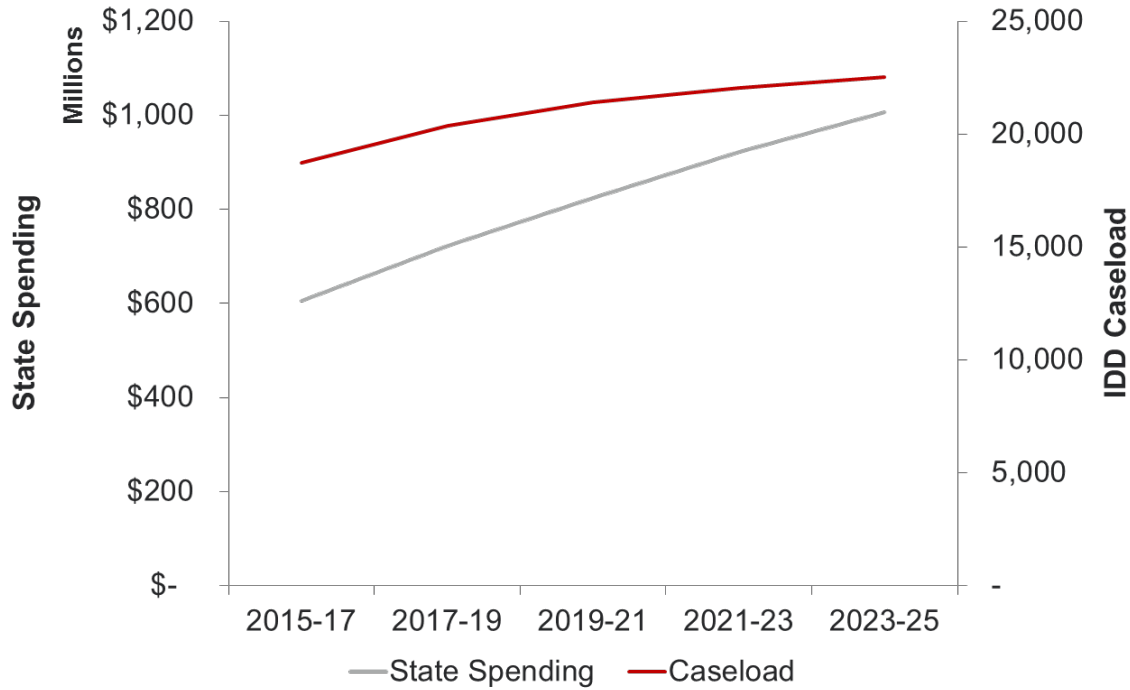
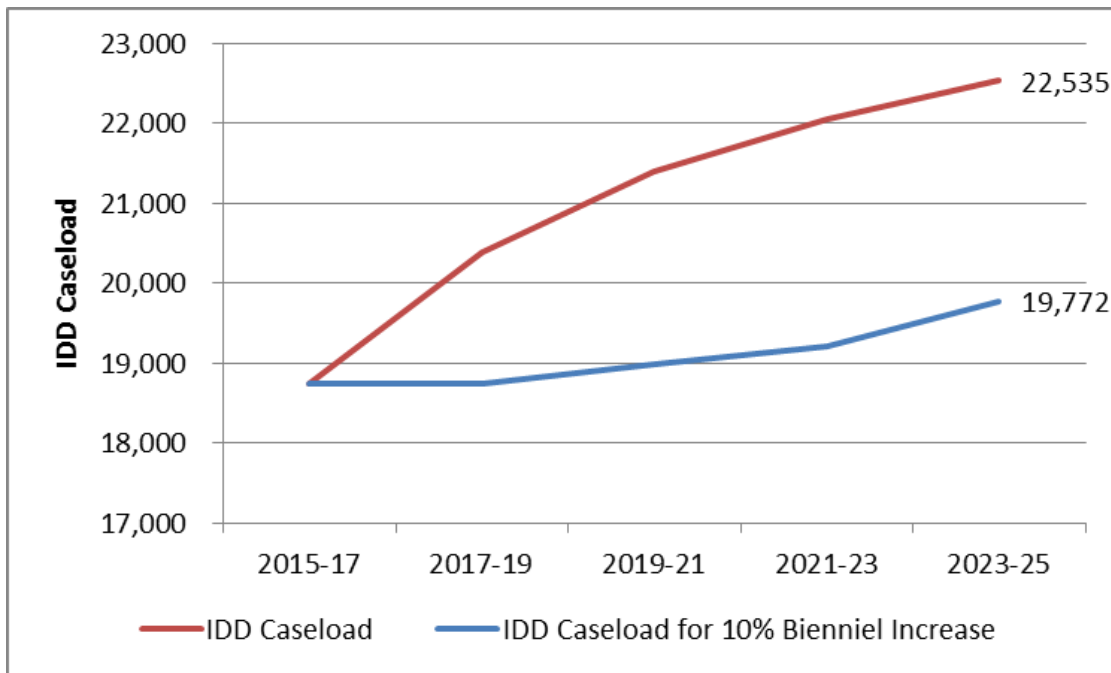


Exhibit 20 shows the necessary change in the number of IDD LTSS participants (excluding case management only) to reduce state spending increases to 10 percent per biennium. In the 2023-25 period, there would need to be nearly 2,800 fewer participants. This translates into a 5.5 percent increase over the period rather than a 20.3 percent increase, approximately one-quarter the projected increase in the caseload and only 0.5 percent annually. As noted above, by 2023-2025, the baseline projections estimate only a 2.2 percent increase in IDD caseload.

Exhibit 20: Projected IDD Caseload (Excluding Case Management Only) Needed to Meet 10% Biennial Increase, State Fiscal Year 2015-2025



Reduce the Number of or Increase in LTSS Recipients: Specific Scenarios

Scenario: Increase Functional Need Requirement for APD

Currently, for APD HCBS, Oregon uses Service Priority Levels (SPL) 1-13. The nature of the disability for the SPLs is as follows:

- **1-4:** Requires full assistance with any of following, mobility, eating, elimination, and cognition.
- **5-7:** Requires substantial assistance with mobility and assistance with elimination and/or eating.
- **8:** Requires minimal assistance with mobility and assistance with eating and elimination.
- **9:** Requires assistance with eating and elimination.
- **10:** Requires substantial assistance with mobility.
- **11:** Requires minimal assistance with mobility and assistance with elimination.
- **12:** Requires minimal assistance with mobility and assistance with eating.
- **13:** Requires assistance with elimination.

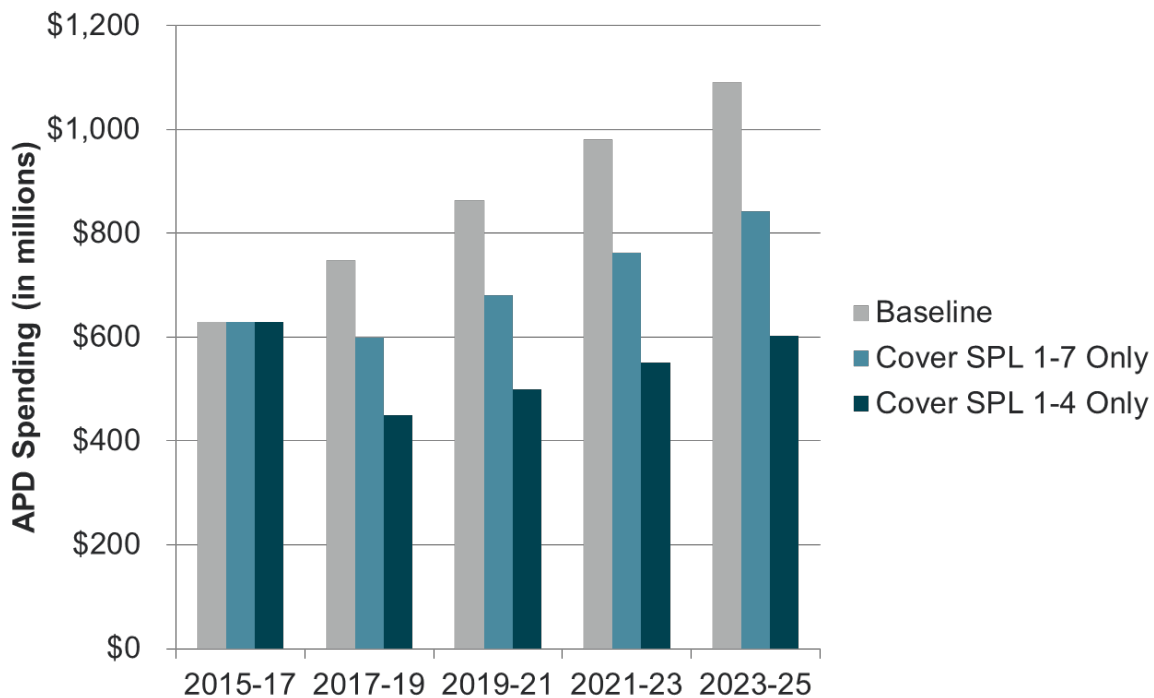
Lewin modeled two scenarios:

1. Include SPL 1-7 only
2. Include SPL 1-4 only

Fiscal Impact

Using the distribution of individuals by SPL, Lewin estimated the number of individuals who would lose eligibility. Unless phased in over time, this loss of eligibility would result in a one-time reduction in the number of individuals receiving APD HCBS services. Instead of an 18.9 percent increase in state APD spending from 2015-2017 and 2017-2019, we estimate the increase would be a decline of 4.9 percent for the SPL 1-7 scenario and a decline of 28.7 percent for the SPL 1-4. Following this one-time decline in participants, the rate of increase returns to nearly the baseline projection rate of increase for 2019-2025. Those remaining in the program would have a higher average per participant spending because of higher acuity remaining in programs.

Exhibit 21: Projected APD Expenditures by SPL Categories, State Fiscal Year 2015 -2025



Consumer Impact

Changes to the SPL requirement would have a significant impact on participants. Lewin estimates that the SPL 1-7 scenario would result in approximately 5,400 or 18 percent fewer APD participants, while the SPL 1-4 scenario would result in 14,300 or 48 percent fewer participants. Not unexpectedly, stakeholders overwhelmingly opposed changes to the SPL requirement.

Implementation

Implementing changes to the SPL requirements would require 12-18 months and a major participant and provider engagement strategy. DHS would need to submit a State Plan Amendment to CMS and could expect potentially lengthy negotiations. With CMS approval, implementation would require an OAR change process.

Scenario: Increase Functional Need Requirement for IDD

Oregon bases eligibility for IDD services on either Intellectual Disability (ID) or Developmental Disability (DD) diagnosis confirmed through a medical or clinical evaluation by a qualified professional, such as a medical doctor or licensed clinical psychologist. With an Intellectual Disability, the IQ score must be 75 or less, with significant adaptive impairment attributed to the disability evident prior to age 18. With a Developmental Disability the condition must require supports similar to an individual with ID, originate in and directly affect the brain, and be present prior to age 22. There must be significant impairment in adaptive behavior attributed to the diagnosis. IQ scores are not relevant when making a determination based on Developmental Disability. Note: “significant impairment in adaptive behavior” requires at least two areas of adaptive impairment on a standardized adaptive assessment (such as the ABAS or Vineland) which are at least two standard deviations below the mean as completed by a qualified professional.

After confirmation of eligibility for IDD services, a case manager reviews the person’s file and interviews the person and/or those who know the person well to document the individual’s current skill levels relating to adaptive impairment including self-direction, self-care, receptive or expressive language or communication, learning or cognition, gross motor or social interaction in order to complete a Level of Care assessment form. Although two areas of adaptive impairment are required for IDD eligibility, only one area of significant impairment in adaptive behavior is required to meet level of care.

Based on this information, there are two options to modify eligibility and level of care to decrease the number of individuals currently being served and to limit the number of enrollments. First, IQ requirements could be modified to require IQs of 70 or less to be eligible for services. Additionally, eligibility and level of care requirements could be increased to require three areas of significant impairment in adaptive behavior for individuals who qualify due to a Developmental Disability.

Fiscal and Consumer Impact

Increasing the number of areas required to meet institutional level of care or modifying IQ requirements among individuals with IDD would result in a one-time reduction in the number of individuals eligible for services and likely higher per participant payments due to the higher need levels. The state does not have easily accessible data regarding the number of areas of impairment among current IDD participants. As a result, Lewin was unable to estimate either the fiscal or consumer impact.

Implementation

Implementing changes to IDD level of care requirements would require 12-18 months and a major participant and provider engagement strategy. DHS would need to submit a State Plan Amendment to CMS and could expect potentially lengthy negotiations. With CMS approval, implementation would require an OAR change process. Any changes to children’s Medicaid eligibility will need to be considered under the maintenance of eligibility requirements in effect through September 30, 2019 and would likely involve negotiations with CMS to make changes prior to this date.

Reduce the Rate of Increase in Payments per Participant: Overview

The projected increases in APD and IDD state spending are driven, in part, by increases in the amount of in-home services received. Limiting the amount spent per participant can reduce expenditures for both populations.

For APD participants, the average payment per participant is projected to increase from about \$54,000 per year in the 2015-2017 biennium to over \$75,000 per year in the 2023-25 biennium. These estimates include nursing facility residents.

Exhibit 22: Projected APD State Expenditures and Per Member Per Year (PMPY) Costs, State Fiscal Years 2015-2025

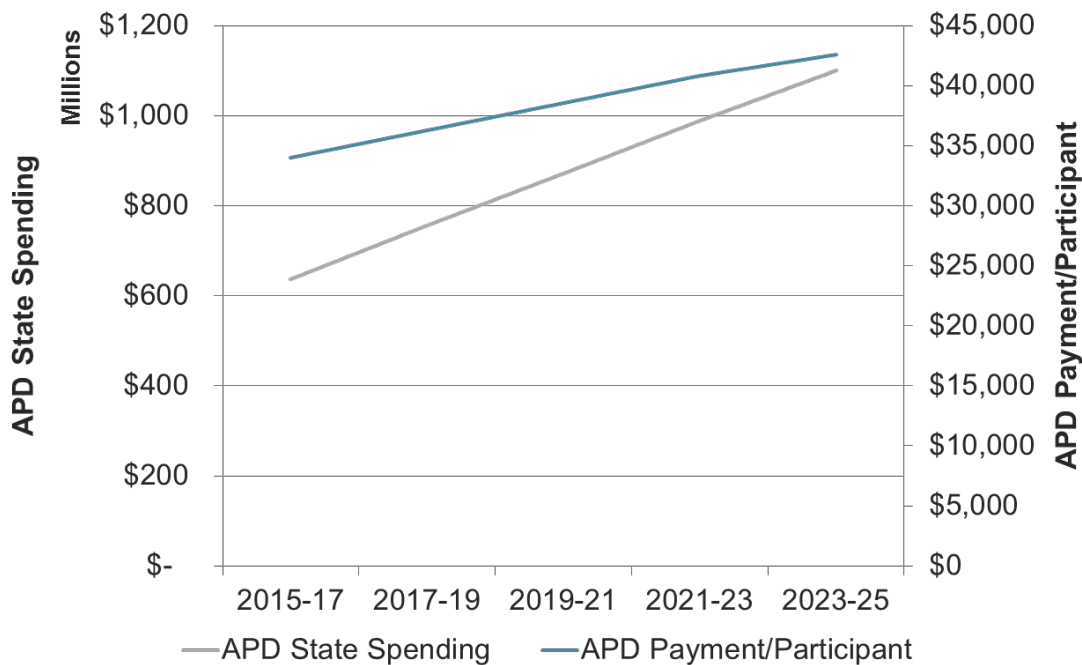
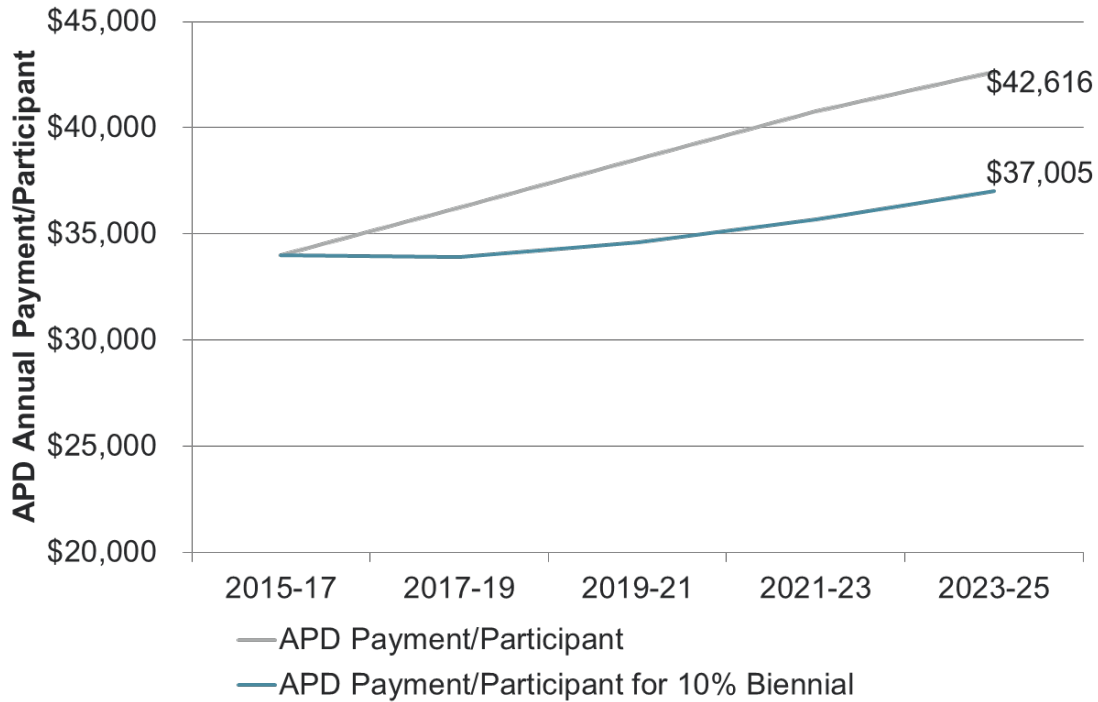


Exhibit 23 below illustrates the amount of the APD individual expenditure limit required in each biennia to limit expenditure to 10 percent growth. This scenario would limit the growth in APD per participant from approximately \$34,000 per year in the 2015-17 biennium to \$37,005 in the 2023-25 biennium.

Exhibit 23: Projected APD PMPY Needed to Meet 10% Biennial Increase, State Fiscal Year 2015-2025



For IDD participants, the average payment per participant (excluding case management only) is projected to increase from \$53,800 per year in the 2015-2017 biennium to over \$74,670 per year in the 2023-25 biennium.

Exhibit 24: Projected IDD State Expenditures and PMPY Spending (Excluding Case Management Only), State Fiscal Year 2015-2025

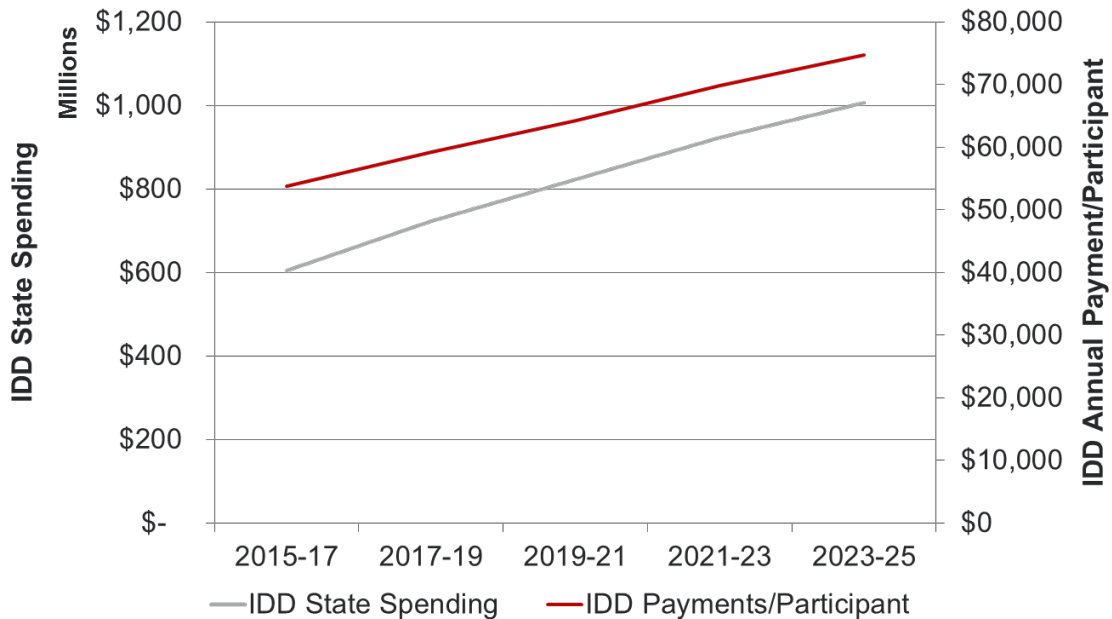
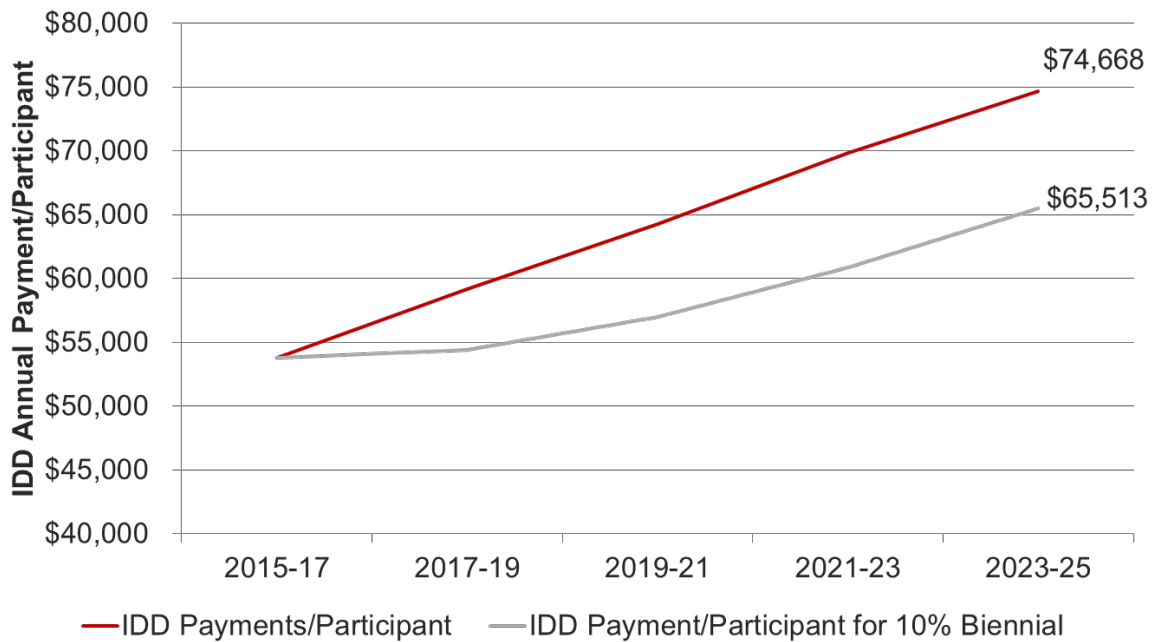


Exhibit 25 below illustrates the amount of the IDD individual expenditure limit required in each biennia to limit expenditure to 10 percent growth. This scenario would limit the growth in IDD per participant from approximately \$55,000 per year in the 2015-17 biennium to \$65,500 in the 2023-25 biennium.

Exhibit 25: Projected IDD PMPY Spending Needed to Meet 10% Biennial Increase, State Fiscal Year 2015-2025



The following discussion explores the impacts of reductions to per participant spending obtained by revisiting service allocation determination by level of acuity and reducing the rate of increase in provider payments. The 1915(k) authority, under which the Oregon K Plan operates, allows states to establish the amount, scope and duration of services, similar to other state plan services. Oregon currently determines LTSS allocations based a variety of functional assessments. The results of the assessments determine the applicable provider payment rate (for Group Home/Foster Care/Supported Living) or number of authorized hours for in-home supports. ODDS reports that the current allocation method for IDD tends to allocate more hours than participants actually use. Revisiting the current allocations for the amount of hours a participant may receive for in-home services would allow the state to better align allocations with support need and also potentially curb spending through reduced allocations for both IDD and APD participants. For IDD in particular, the data collected on actual use relative to allocations based on the ANA/CNA since the implementation of the K Plan will allow for refinements to these instruments that were developed under very tight timeframes.

Fiscal Impact

The fiscal impact of changes in service allocation and provider rate increases on APD and IDD will vary based on how the changes are structured. Service allocation ceilings for in-home services could be designed to generate the amount spending equal to the 10 percent target.

Consumer Impact

The consumer impacts will vary based on the approach. Revisions to service allocations based on acuity for APD and IDD would result in individual consumers receiving fewer services. Reductions to the amount of provider rate increases would not impact the number of consumers who receive services. Individuals without available natural supports would be more negatively impacted than those with natural supports available to replace reduced paid supports.

Implementation

Reduction in the rate of increase in provider payments for in-home services requires changes to the union contracts for the 2015-2017 biennium affecting both APD and IDD.

Change Participant Cost-share: Repeal the In-Home Allowance

As discussed in the Background section, the addition of \$500 above the SSI limit (currently \$1,233/month) helped Oregon meet its required and ongoing maintenance of effort expenditures predicated on an additional 6% FMAP (Federal Medical Assistance Percentage) for services provided by Aging and People with Disabilities and Developmental Disabilities programs. Although the income eligibility remains the same for in-home services, participants retain more of their own resources to cover their non-service expenses, such as mortgage/rent, utilities, food, personal needs, etc. This change allows consumers to retain a higher portion of their income to remain in their own homes, but impacts the overall program budget as a result of the reduction in service contributions from program participants.

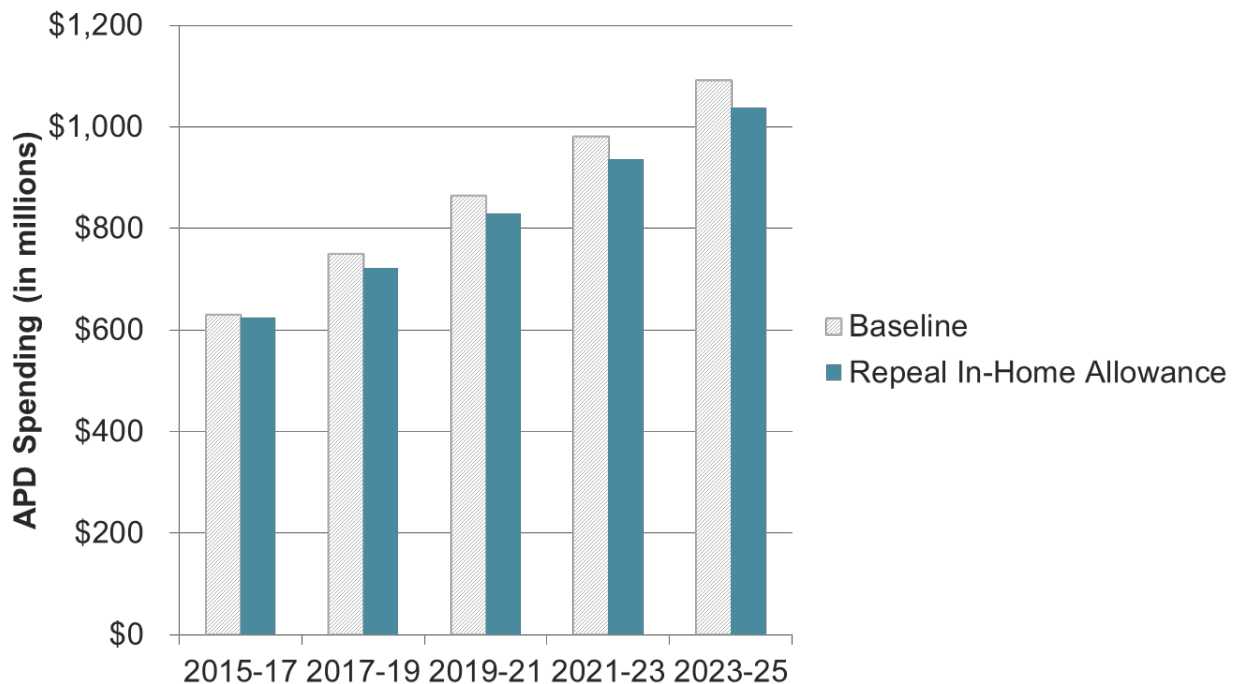
Since ODDS does not collect cost-share from its participants at this time, a repeal of the in-home allowance presents a particular challenge to ODDS' efforts to support participants' employment. Participants with IDD will have little incentive to seek and retain employment if all of their earnings above SSI payments must be contributed to their cost of services. This will also make it difficult for ODDS to comply with the *Lane v. Brown* settlement requirements related to employment supports and the expansion to the Employment First program. In modeling the repeal of the in-home allowance, Lewin developed estimates for APD only.

Fiscal Impact

Repealing the in-home allowance would result in a four to five percent reduction in overall APD service spending as participants with income above SSI no longer retain the up to \$500/month housing allowance (see **Exhibit 26**). We assumed a small reduction in the rate of increase (10 percent) in the caseload to account for individuals with income above SSI who chose not to seek services because they wish to remain in their own home and would be unable without the housing allowance. Using the distribution of income for people with disabilities from the American Community Survey, we also estimated that the state's payments for in-home services would experience a one-time decline of \$135 per member per month once the repeal goes into effect. As a result, instead of an 18.9 percent increase in state APD spending from 2015-2017 and 2017-2019, we estimate the increase would be 15.6 percent. Following this one-time payment decrease as a result of the increased participant cost-share, the rate of increase returns to levels close to the baseline projected rate of increase for 2019-2025. This estimate does not take

into account individuals who might choose nursing facility or residential services (assisted living, residential care and adult family homes) over in-home services. Nor does it factor in the cost of individuals seeking services at higher acuity and greater decline due to acute events.

Exhibit 26: Fiscal Impact on State APD Spending with Repeal of \$500 In-Home Allowance, State Fiscal Year 2015-2025



Consumer Impact

Not unexpectedly, stakeholders overwhelmingly opposed the loss of up to \$6,000 annually to cover living expenses. For those able to retain their own income up to \$500/month, their income available for living expenses will go from \$15,276 to \$9,276. Lewin estimates that approximately 20 percent of in-home participants retain the full \$500/month and another 12 percent retain less than \$500/month. Some individuals might choose nursing facility or residential services (assisted living, residential care and adult family homes) over in-home services and some may delay seeking services at higher acuity and greater decline due to acute events.

Implementation

Repealing the in-home allowance would require an OAR change process. It would also require making changes to programming code in the Medicaid management information systems putting the timeline at least six months and likely a full year. The state will need to consider cross system implementation of the change in income allowance. The state would also need to notify CMS. Lewin does not expect CMS to have any issues with the change because Oregon has more than met the maintenance of effort requirements associated with the K Plan.

Increase Integration

Most individuals that have difficulty with accomplishing day-to-day activities, ranging from shopping to preparing their own meals to being able to dress and feed themselves – instrumental activities of daily living (IADLs) and activities of daily living (ADLs) – also have multiple chronic conditions. Among those with chronic conditions, those with ADL/IADL impairments have increased average health spending, regardless of the number of chronic conditions.¹² Greater integration and service coordination through interdisciplinary teams between primary, acute and long-term services and supports:

- Can provide participants better and holistic care
- Has potential to reduce unnecessary services, particularly for acute care
- Could result in smaller increases in spending

State-administered MLTSS

Currently, DHS and the taxpayers of Oregon assume all of the risk associated with providing LTSS. To facilitate migration to a state-administered MLTSS system, DHS and its community partners could continue to manage LTSS, but incorporate integration principles and training into the approach and monitoring of the overall system. Through contractual levers, DHS could build in expectations for enhanced integration and collaboration across community-based and acute care providers, as well as incorporate incentive payments for achievement of integration benchmarks over a defined period of time. Contracts might include minimal requirements for training of front-line professionals who play a role in care coordination and development of inter-disciplinary teams.

Fiscal Impact

Movement toward a State-administered MLTSS system has the potential to reduce administrative overhead while offering greater cost control. Small financial incentives or shared savings to providers under a managed care environment can build capacity for greater integration and collaboration across acute and community-based long term providers. Incentive payments can increase as benchmarks are achieved (e.g. reduced unnecessary hospital admissions, utilization of less costly LTSS services, reduced polypharmacy and overuse of medications). Such incremental change both builds provider capacity across managed care organizations and community-based organizations, trust among those providers and the relationships necessary to sustain strong partnerships, as well as bending the cost curve reinvesting savings into lower cost alternatives.

¹² “Individuals Living in the Community with Chronic Conditions and Functional Limitations: A Closer Look” (2010). Alecxih, L., Shen, S., Chan, I., and Drabek, J. for the Office of the Assistant Secretary for Planning and Evaluation at <http://aspe.hhs.gov/daltcp/reports/2010/closerlook.pdf>.

Consumer Impact

Consumers may be served in a more cohesive and holistic manner in a State-administered MLTSS system if administered and executed well. Expectations for increased integration across the acute and community-based long-term care system only improves continuity of care, and thus improves transitions of care, supporting individuals in receiving the right services at the right time. The gaps in care and critical healthcare information that supports transitions across settings can be mitigated by expectations for shared healthcare information across providers, use of integrated health records, and interdisciplinary care teams. Stakeholders have strongly expressed their opposition to MLTSS.

Implementation

Implementation of a State-administered MLTSS system requires vision, commitment, and expertise. Oregon has a long history of innovation and vision, along with the expertise to move in this direction. The timeline for execution of such a shift is a long-term effort, requiring potential State and Federal waivers (e.g. 1115 authority), and legislative approval. The State of Vermont provides a solid example for Oregon to study. Starting with 1115 waiver authority back in 2005, over the past ten years they have worked to consolidate all Medicaid funding, including long term services and supports, under one waiver authority with the State Medicaid agency functioning as a publicly-administered managed care organization, assuming all risk for Medicaid funded services to all populations.

Arizona has provided MLTSS for individuals with developmental disabilities through the state's Department of Economic Security/Division of Developmental Disabilities (DES/DDD) since its launch in 1988. DES, a separate state agency from Medicaid, includes the statutorily-authorized division responsible for providing services to persons with IDD. State statute requires DDD to contract with Arizona Medicaid (and vice-versa). DDD negotiates a managed care contract with AHCCCS. The contract specifies DDD's responsibilities for Medicaid members with IDD who have long-term care needs. DDD delivers or arranges for delivery of all services included in the monthly capitation payment:

- Acute care services (hospital, physician, lab, x-ray, etc.) delivered by sub-capitated health plans;
- Behavioral health services provided through Regional Behavioral Health Agencies under the terms of an Interagency Agreement; and
- Long-term care services, including HCBS for persons with IDD, provided on a fee-for-service basis by HCBS providers that serve individuals with IDD.

Greater Integration with Coordinated Care Organizations (CCOs)

Oregon implemented its CCO model in 2012 after CMS approval of its 1115 Medicaid demonstration program. The CCO model does not include LTSS, however does encourage collaboration. A key lever to bend the cost curve is to work to integrate, or better coordinate, CCO models with community-based LTSS providers. An approach Oregon may consider is to promote increased collaboration and integration of LTSS with the CCOs while keeping funding

separate, but incorporating LTSS into CCOs through common outcomes where both CCOs and case managers are held accountable related to LTSS users.

Fiscal Impact

Even while keeping funding streams separate, Oregon may realize a reduction in overall expenditures, or reducing the rate of PMPM growth over time, by working to incorporate LTSS into the CCO model. CCO's could be incentivized to submit annual transformation plans that outline a strategy for encouraging greater coordination with organizations that coordinate LTSS.

Consumer Impact

There is growing evidence and studies that show the more integrated and coordinated delivery systems are, the greater the impact on consumer health outcomes.¹³ Holding CCO's accountable for the cost and quality of services delivered to vulnerable populations provides both financial and quality driven incentives to provide the most appropriate services based on the individual's needs. When consumers are given the opportunity to direct and actively contribute to their overall care, a premise of CCO's and of interdisciplinary team approaches, they often choose less costly services. Better coordinated and integrated care is linked to greater consumer satisfaction, more appropriate use of healthcare services, while lowering overall costs.

Implementation

Oregon already has an 1115 waiver in place for the operations of the CCOs. This waiver could be modified to explicitly include LTSS as part of the CCOs' accountability. However, in developing its 1115 application, Oregon actively considered and rejected this approach.

Oregon may consider incorporating expectations for revised annual CCO transformation plans to include a goal, strategy, and timeline for engaging LTSS providers into their CCO model and overall approach to service delivery. This may take the form of formalized MOU's with a required set of LTSS providers (e.g. ADRC's, behavioral health, AAAs, Centers for Independent Living or Intellectual and Development Disability service providers) outlining how they will work together, to building in shared responsibility for the achievement of a core set of outcomes for populations of CCO members in need of LTSS services provided by LTSS providers. To the degree that such partnerships help the CCO achieve both quality and cost outcomes, over time the CCO may choose to modify financial incentives that share a portion of savings with LTSS providers. Such activities and changes could be integrated into the next wave of transformation plan submissions, with planning and discussions with impacted stakeholders starting immediately.

¹³ Archibald, Nancy & Barth, Sarah Linda, Alice. (December 2015). *Assessing Success in Medicare-Medicaid Integration: A Review of Measurement Strategies*. Center for Healthcare Strategies for Washington State Health Care Authority. And Interim Report to Congress on the Medicaid Health Home State Plan Option. U.S. Department of Health and Human Services Office of the Secretary.

Contract for MLTSS

Oregon may consider transferring acuity and payment rate risk to managed care organizations (MCOs) providing long-term care services by contracting for fixed capitated amounts that could be set to be the same across all members or vary by acuity.

Fiscal impact

Oregon may realize a better forecast of rate growth over time by holding MCOs accountable to capitated amounts with contractual rate increases. Oregon may also cap profits and require reinvestment of any amounts above those levels into services for members similar to New Mexico's behavioral health specialty plans.

Consumer impact

Consumers could be more appropriately served by equalizing the incentives for payment based on a fixed payment amount versus level of acuity. Conversely, consumers could experience potential negative impacts when the MCO is receiving a fixed payment regardless of acuity. Unless the MCO sees the value in ensuring that its members receive the most appropriate services regardless of acuity and will serve all members regardless of potential healthcare utilization, there is a potential that MCOs will try to reduce service options or service authorizations to maintain costs within a fixed payment. If MCOs were to be held accountable for both costs and outcomes, that could be mitigated. A private-market MLTSS approach is not palatable to stakeholders who have expressed concerns about movement towards a medical model of care.

Implementation

Such change will take time, as well as considerable work to gain MCO buy-in to the change, along with modification of the state payment system. It will also require contractual modifications to be executed across all MCO providers. Estimated time for implementation is at least one year to eighteen months. An important consideration under such an approach is whether to allow individuals who receive Medicaid LTSS to opt in, opt out, or require participation in MLTSS. Decisions about the level of choice left to LTSS participants will influence which authorities might be pursued; including an amendment to the current 1115 waiver or possibly pursuing a 1915(a) or 1915(b) waiver in conjunction with the 1915(k) which has not been approved by CMS to date (1915(a)/(c) and 1915(b)/(c) combinations have been approved).

New York State is implementing a Fully Integrated Duals Advantage Plan for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD Plan). The plan will provide integrated benefits to those Medicare-Medicaid Enrollees who reside in the targeted geographic area and who choose to participate in the Demonstration. This program is part of the larger financial alignment initiative CMS is utilizing to demonstrate that coordination of Medicaid and Medicare benefits, along with funding streams, will result in better care and financial integrity. The program, executed through a memorandum of understanding relying on 1115, 1915(a), and 1915(c) waivers, is a partnership between: New York State Department of Health, the Office for People with Developmental Disabilities, CMS, and Partners Health Plan. The State estimates 10,000 potential enrollees in the

eight counties participating in the demonstration. The anticipated date of opt-in enrollment is April 1st, 2016.

In 2012, in response to the impending implementation of the Financial Alignment Medicare-Medicaid demonstration and poor outcomes from the existing waiver administrator, CareStar, the Ohio Department of Medicaid decided to bid out the management of two HCBS waivers – the Home Care Waiver for Medicaid-eligible individuals under 60 with a nursing facility level of care and the Transitions waiver serving individuals over age 60 requiring either an intermediate or skilled level of care. The existing community agency, as well as CareSource, a managed care company, were both awarded contracts. The award to CareSource represented the first time Ohio had selected a managed care company to administer HCBS waivers in the state. The introduction of two service administrators resulted in competition that required the community-based agency to improve the quality of services and offered individuals a choice regarding management of their waiver services.

Leverage Technology

States are increasingly turning to in-home technologies to help individuals remain in the community. Telehealth is becoming a common way to provide access to health services, especially in rural or remote areas. However, simple technologies such as broadband communication, web cameras, and sensors can be used to help individuals stay in their homes safely and independently. Access to 24/7 communication tools also facilitates connections with family members who may not be able to physically take part in providing care. As part of a statewide broadband effort, Maine is developing a program to employ telehealth technologies to help seniors enrolled in Medicaid to stay in their homes longer. One case study suggests that telehealth can help prevent hospital readmissions in older adults. The Lutheran Homes of Michigan established the Aging Enriched Network, an information and referral network that offers access to a variety of services aimed to help older adult stay in their homes, including telehealth and monitoring services. In a small study of the telehealth program, 12 of the 15 people who were discharged from the hospital without a telehealth device experienced a readmission or unexpected physician visit compared to one or two of the individuals in the telehealth program.¹⁴

Indiana has contracted with a company called ResCare to provide remote monitoring for people with disabilities. Using web cam technology along with web-based interactive devices such as sensors, microphones, and personal emergency response systems, one person is able to monitor multiple individuals at different locations. An evaluation of a “smart home” project in the apartments of nine residents of an independent retirement facility looked at the implementation of an In-Home Monitoring System (IMS) composed of wireless infrared proximity sensors to detect motion and pressure switch pads. The IMS also used stove, cabinet and bed sensors. The study indicated that residents reacted positively to the sensor technologies and did not feel they interrupted daily activities or raised privacy concerns¹⁵. Simple technologies can also be used to provide cueing and reminders for individuals who may only need minimal assistance. In addition, some states have adopted electronic visit verification as a way to monitor fraud and abuse.

Fiscal impact

While the fiscal impact of enhanced use of technologies will vary, cost savings have been achieved by reducing numbers of care providers and reliance on institutional care.

¹⁴ Gehm, D. (2011). Lutheran Homes of Michigan. *Preparing for the Future: Developing Technology-Enabled Long-Term Services and Supports for a New Population of Older Adults*. LeadingAge CAST Report.

¹⁵ Demiris, G., Oliver, D.P., Dickey, G., Skubic, M., & Rantz, M. (2008). Findings from a participatory evaluation of a smart home application for older adults. *Technology and Health Care*, 16, 111-118.

Consumer impact

Increased use of technology can enable individuals to stay in their homes and communities and promotes greater independence. Stakeholders expressed interest in the possibilities citing that it could be useful for removing some of the social disincentives around having a personal care worker. However, they emphasized the need to preserve privacy and dignity in respects to home monitoring. Concerns were also raised that any remote monitoring should not be sourced outside of the state.

Implementation

Access to needed technologies is widespread, most employ off-the-shelf products. In addition, there are a growing number of companies providing telecare services. Many states, including Oregon, have adopted laws governing the use of telehealth. Waivers and state plan amendments may be necessary to adopt certain services. DHS would need to develop policies and procedures around authorization, reimbursement, and usage as well as training to ensure successful adoption.

Stakeholder Feedback

In the initial phases of this study, Lewin solicited input from a wide range of stakeholders, including advocates, consumers, county/local government, providers, and state staff, on the current state of Oregon's long-term support and services (LTSS) system, including reaction to the K Plan and areas for improvement. Stakeholders had two opportunities to provide feedback to Lewin: 1) an electronic survey emailed to a list of stakeholders provided by DHS; and 2) an in-person meeting held January 19, 2016, in Salem. About 50 people representing both APD and IDD stakeholders attended the in-person meeting and they responded to several potential policy strategies used in other states or described in policy reports to control costs associated with long-term services and supports.

What Stakeholders Value

Overall, stakeholders for both APD and IDD programs highly valued the array of home and community-based supports available to enable individuals to avoid restrictive living situations. Consumer choice and person-centered services were cited as positive aspects of the system. IDD stakeholders also noted that family networks and added support services are also valuable, for it enhances individual's quality of life.

Stakeholder Reactions to Potential Policy Changes

Stakeholders' consistent message was that the current level of spending for the programs was unsustainable, which called for modifications in the funding structure and program implementation. A number of IDD stakeholders indicated the need for eligibility modifications because they considered the current eligibility criteria too broad.

Several stakeholders indicated their dislike of enrollment caps and managed LTSS. There was agreement that eligible persons should get the service and that limiting services is preferred over capping enrollment. The group generally agreed that managed LTSS will not be accepted in Oregon. People asked for evidence that managed LTSS has been successful in other states. Similarly, it was noted that PACE is an expensive model that is not cost effective.

Other notable areas of modification identified included: increase Medicaid funding for pre-eligible individuals as a preventative measure (avoid more expensive services); increase program accountability and oversight; and enhancing programs that provide care outside of institutions. Regarding changes in waiver authorities, stakeholders suggested that the state examine the number of hours associated with actual need. The assessment language could be more consistent and the CAPs program's integrity could be improved.

Individuals representing IDD programs identified the potential for redesign of the assessment tool to better assess natural supports. One person stated that natural supports might not be available to people age 18 or older. Overall, IDD program stakeholders sought more effective administrative processes, allocation of funding and payment rates, volume control, and additional changes to eligibility or services need to be made for a more sustainable program. One person asked that the state not dis-incentivize work by reviewing parental income for kids under age 18. Some children have very expensive needs, and two-income families should not have to become impoverished to receive services. Related to potential rate adjustments, some noted that in prior years, IDD providers had to take cuts which destabilized some aspects of the program.

Stakeholder preferred slowing the rate of increasing wages for bargained workers over rate reductions to promote stability.

Technological solutions might work well in rural communities and for people who want or need an alternative to a paid attendant, but please do not send jobs out of state or country. One person suggested that the rule regarding enhanced supervision through technology should be revised because technology could be less expensive than one-to-one staffing. Overall, respecting privacy and dignity should be the basis for technological options.

A provider suggested that efficiencies could be identified if the state would work with providers to understand operational costs, especially those linked to OARs. Another provider mentioned the impact of the minimum wage act, which will increase provider expenses and result in a loss of providers. And an advocate suggested that the cost curve would be addressed with intervention and prevention approaches, such as preventing an expensive crisis.

The additional federal funding coming from the K Plan was viewed as valuable, though there was some discussion that the K Plan may not be the best option for IDD services and that certain IDD services could be better controlled in a waiver.

The meeting ended with one advocate emphasizing that the system has been solid and well liked in the past and that stakeholders will fight to retain that reputation. Further, it was suggested that the state think outside the box and ignore what other states have done.

Appendix A: Overview of Oregon's Long-Term Care Eligibility Requirements

The table below outlines the eligibility determination requirements for individuals receiving LTSS under the Oregon Aged & Disabled Waiver and Oregon Intermediate Care Facility/Intellectual and Developmental Disability Comprehensive Waiver.

Service Priority Levels were established for several reasons:¹⁶

- To enable eligible individuals to remain in the least costly and restrictive setting according to their service needs;
- To serve those individuals in greatest functional need and have no or inadequate alternate resources to meet their needs;
- To assure access to services provided by the Department of Human Services to eligible individuals;
- To assure that services provided to eligible individuals and paid for by the Department are safe and adequate; and
- To enable the greatest number of individuals to be served based on a system of prioritization that serves those individuals in greatest need and with no or limited alternate resources. With a program of limited resources, this is the most efficient method in which to ensure individuals with greatest need, and at highest risk of institutional placement are served in a more preferred and less costly setting.

¹⁶ OR Department of Human Services, Aging and People with Disabilities, OR Administrative Rules Chapter 411, Division 15 Long-Term Care Service Priorities for Individuals Served.

Oregon's Eligibility Determination Requirements for Individuals Receiving LTSS

Older Adults

Adults with Physical Disabilities

- 18 or over
- Eligible for the Medicaid OHP Plus benefits package
- Meet the functional impairment level within the service priority levels currently served by the Department
- **Current Limitations** include serving individuals meeting Service Priority Levels (1-13) OR
- Oregon Independence Plus eligible and meets any Service Priority Level (1-18) OR
- Needing risk intervention services in areas designated to provide such services. Individuals with the lowest service priority level number are served first.

Service Priority Levels

Assist or full assist with Activities of Daily Living (ADLs) in the following priority order:

1. *Full Assistance in Mobility, Eating, Elimination, and Cognition*
2. *Full Assistance in Mobility, Eating, and Cognition*
3. *Full Assistance in Mobility, or Cognition, or Eating*
4. *Full Assistance in Elimination*
5. *Substantial Assistance with Mobility, Assistance with Elimination and Assistance with Eating*
6. *Substantial Assistance with Mobility and Assistance with Eating*
7. *Substantial Assistance with Mobility and Assistance with Elimination*
8. *Minimal Assistance with Mobility and Assistance with Eating and Elimination*
9. *Assistance with Eating and Elimination*
10. *Substantial Assistance with Mobility*
11. *Minimal Assistance with Mobility and Assistance with Elimination*
12. *Minimal Assistance with Mobility and Assistance with Eating*
13. *Assistance with Elimination*
14. *Assistance with Eating*
15. *Minimal Assistance with Mobility*
16. *Full Assistance in Bathing or Dressing*
17. *Assistance in Bathing or Dressing*
18. *Independent in the above levels but requires structured living for supervision for complex medical problems or a complex medication regimen.*

Children with IDD

Intellectual Disability

- Diagnosis by age 18
- IQ of 75 or below eligible if:
 - They have significant impairment in one area or more areas of adaptive behavior. Areas of adaptive behavior include adaptive, self-direction, self-care, receptive or expressive language or communication, learning or cognition, gross motor, or social interaction. AND
 - They do not need specialized mental health treatment services or other specialized Department residential program interventions as identified through the mental health assessment process or PASRR process
- Adaptive impairment cannot be primarily related to any of the following:
 - mental/ emotional disorders
 - sensory impairments
 - substance abuse
 - personality disorder
 - learning disability
 - ADHD

Other Developmental Disabilities

- Diagnosis by age 22 with origin in the brain
- Must have either an official medical or clinical diagnosis of a disability and a significant impairment to adaptive functioning that is directly related to the specific disability
- Adaptive impairment cannot be primarily related to any of the following:
 - mental/ emotional disorders
 - sensory impairments
 - substance abuse
 - personality disorder
 - learning disability
 - ADHD
- Must result in significant impairments in at least two areas of daily functioning: self-care, communication, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency.

Appendix B: Relevant Medicaid Authorities

The chart below summarizes Federal authorities that may be useful in restructuring Medicaid health care delivery or payment, and that can be exercised through State Plan Amendments or waivers. The chart highlights flexibilities and limitations of each authority and is a technical assistance resource developed for the Centers for Medicare & Medicaid Services by the Center for Health Care Strategies and Mathematica Policy Research and can be found at <https://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/At-a-glance-medicaid-Authorities.pdf>.

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS
Section 1915(a) Exception to State Plan Requirements for Voluntary Managed Care	Used to authorize voluntary managed care programs on a statewide basis or in limited geographic areas implemented through CMS Regional Office approval of the managed care contract. The state has the ability to use passive enrollment with an opt-out within this authority.	<ul style="list-style-type: none"> • No waiver or state plan amendment required. • No mandatory enrollment or selective contracting allowed
Section 1915(b) Waivers	<p>Two-year (or five-year, if serving dual eligibles), renewable waiver authority for mandatory enrollment in managed care on a statewide basis or in limited geographic areas.</p> <p>1915(b) waivers must not substantially impair beneficiary access to medically-necessary services of adequate quality.</p>	<ul style="list-style-type: none"> • Allows for mandatory managed care or PCCM enrollment for dual eligibles for Medicaid services through 1915(b)(1) authority. • Locality may act as a central enrollment broker through 1915(b)(2) authority. • May provide additional, health-related services through 1915(b)(3). • Allows for selective contracting under 1915(b)(4) authority. • Can identify excluded populations. • Comparability of services, freedom of choice and statewideness are not required. • Must be determined to be cost-effective and efficient. Waiver requirements are more administratively burdensome than 1915(a) or 1932(a).
Section 1915(c) “Home and Community-Based Services (HCBS)” Waivers	Renewable waiver authority that allows states to provide long-term care services delivered in community settings as an alternative to institutional settings. The state must select the specific target population and/or sub-population the waiver will serve.	<ul style="list-style-type: none"> • Freedom of choice is required absent a concurrent Medicaid authority that permits the state to waive this requirement. • Can implement in limited geographic areas. • Comparability of services with non-waiver enrollees is not required;

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS
	<p>1915(c) waivers are renewable for 5 years after the initial, 3-year approval (or, if applicable, initial 5-year approval).</p>	<p>however, services must be comparable within the waiver population.</p> <ul style="list-style-type: none"> • Must demonstrate cost neutrality. • Must specify the maximum number of participants for each waiver year, and criteria for selection of entrants. • May include individuals with income up to 300% of the Federal SSI benefit rate.
<p>Concurrent 1915(b)/(c) Waivers</p>	<p>Used to implement a mandatory or voluntary managed care program that includes waiver HCBS in the managed care contract. The 1915(c) waiver allows a state to target eligibility and provide HCBS services. The 1915(b) then allows a state to mandate enrollment in managed care plans that provide these HCBS services, and to exercise other 1915(b) options, such as selective contracting with providers.</p> <p>States must apply for each waiver authority concurrently and comply with the individual requirements of each.</p>	<ul style="list-style-type: none"> • Allows for selective contracting with providers. • Requires administration of two separate concurrent waivers with separate reporting requirements.
<p>1915(k) Community First Choice</p>	<p>Allows states to provide home- and community-based attendant services and supports for beneficiaries on a statewide basis. States must cover assistance and maintenance with ADLs/IADLs and health-related tasks; ensure continuity of services and supports; and provide voluntary training on how to select, manage and dismiss staff. Services can be provided through an agency or a self-directed model.</p> <p>This does not create a new eligibility group; eligible individuals are those who are eligible for Medicaid under the state plan, have incomes up to 150% FPL or over 150% FPL and meet institutional levels of care standards.</p>	<ul style="list-style-type: none"> • State has the option to cover transition costs, expenditures related to participant’s independence and services, or supports linked to an assessed need or goal. • Financial management services must be available when provided through a self-directed model. • Cannot waive statewideness

AUTHORITY	DESCRIPTION	KEY FLEXIBILITIES AND/OR LIMITATIONS
<p>Section 1115 Demonstrations</p>	<p>Broad waiver authority at the discretion of the Secretary to approve projects that test policy innovations likely to further the objectives of the Medicaid program. Permits states to provide the demonstration population(s) with different health benefits, or have different service limitations than are specified in the state plan. Granted for up to 5 years, and then must be renewed.</p>	<ul style="list-style-type: none"> • Must further the objectives of the Medicaid program. • Requires some eligibility or benefit expansion, quality improvement, or delivery system restructuring to improve program. • Must have a demonstration hypothesis that will be evaluated with data resulting from the demonstration. • Provides most flexibility of all Medicaid authorities to waive Medicaid requirements. • Comparability of services, freedom of choice, and statewideness are not required. • Must be budget neutral. • Managed care enrollment may be voluntary or mandatory.