HMA

HEALTH MANAGEMENT ASSOCIATES

Methods to Fund Long-Term Care

PRESENTED TO
THE CAMPAIGN FOR OREGON'S SENIORS & PEOPLE WITH DISABILITIES
(COSPD)

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Executive Summary

Oregon has been a leader in funding home and community-based services

Oregon has long been a leader in funding home and community-based care as an alternative to institutional care. In the 1990s, Oregon was recognized as one of three states (the others being Washington and Wisconsin) that had already shifted care from nursing homes to the community reducing the ratio of nursing home beds per 1,000 persons 65 years of age and older from 47 in 1982 to 36 in 1992.[1] This shift has continued, with Oregon having only 24 beds per 1,000 persons 65 years of age and older in 2010 compared to the national average of 42.

Oregon was recently ranked third among the 50 states and Washington, D.C., across four dimensions of long-term system and supports (LTSS) system performance:

1. Affordability and access
2. Choice of setting and provider
3. Quality of life and quality of care
4. Support for family caregivers.[2]

(See Tables A-1 and A-2 for additional LTSS measures.)

Oregon's other outstanding rankings include:

3rd	Percentage of Medicaid long-term care spending on home and community-based services (HCBS[3]) for the aged and disabled (2009)[4]
2nd	Number of assisted living and residential care units per 1,000 population age 65+ (2010)
4th	Single entry point (ADRC) functionality (2009)
3rd	Number of adult consumers self-directing their services (2009)
5th	Percent of adults with disabilities reporting they usually or always get needed supports (2009)
1st	Access to caregiver supports (composite indicator)[5]
1st	Degree to which health maintenance tasks can be delegated (2011 - 1 of 4 states with this rank)

[1] "Successful State Efforts to Expand Home Services While Limiting Costs." United States General Accounting Office. Web. 1 Dec. 2011.

[2] Reinhard, Susan C., Enid Kassner, Ari Houser, and Robert Mollica. "Raising Expectations - A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." AARP, The Commonwealth Fund, and The Scan Foundation. Sept. 2011. Web. 1 Dec. 2011.

[3] HCBS include personal care, home health, PACE, and HCBS targeting older adults and people with physical disabilities authorized under Sections 1115, 1915(c), 1915(j), and 1929.

[4] In Oregon referred to as Seniors and People with Physical Disabilities (SPDs). Aged and Disabled (AD) is a Medicaid eligibility categorization.

[5] Access to Caregiver Supports was ranked based on three indicators: Percent of family caregivers getting needed supports (2009), state policies that exceed federal Family and Medical Leave Act (FMLA) requirements (2011), and the state's permitted number of delegated health maintenance tasks (2011). This score could be adversely impacted by DHS elimination of funding for local coordination of respite care services effective July 1, 2010.

States that have invested in home and community-based services over the long term have reduced their long-term care costs

A national analysis of state spending data from 1995 to 2005 shows that spending growth was greater for states offering limited non-institutional services than for states with large, well-established non-institutional programs. States that expand home and community-based services over the long term, which is the case in Oregon, experience a reduction in institutional spending and achieve long-term cost savings.[6]

Oregon, like many states, is facing a budget crisis

Oregon is seeking methods to balance the state's budget in light of declining revenue and increased Medicaid enrollment. States have limited options for reducing Medicaid costs. These include:

- Reduce reimbursement rates.
- Reduce program enrollment or eligibility.
- Reduce services (amount, duration or scope).
- Reform or modify its health care delivery or payment systems.
- Increase Medicaid revenue through new provider taxes, non-provider taxes or intergovernmental transfers.

Some options, such as reducing enrollment through eligibility changes or reducing services, are limited by federal maintenance of effort (MOE) provisions in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (together known as the Affordable Care Act).[7] Reductions in provider reimbursement rates are limited by federal equal access standards and federal court decisions, including those made by the 9th Circuit Court, which govern the federal courts in Oregon. Reductions in services are limited by requirements by the Olmstead decision, which limits a state's ability to reduce services that help beneficiaries avoid being cared for in an institutional setting.

Oregon has an adequate nursing home bed supply, but the supply could become inadequate if HCBS are reduced

Oregon appears to have an adequate nursing home bed supply to meet future demand through 2020 as the population 65 years and older grows, assuming Oregon maintains its current long-term care utilization patterns. However, any actions that reduce access to HCBS could result in both an increase in nursing home occupancy and a potential future need for additional nursing home beds.

[6] Kaye, H. Stephen, Mitchell P LaPlante, and Charlene Harrington. "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?" *Health Affairs* 28.1 (2009): 262–272.

[7] For more information see the State Medicaid Director letter SMDL#11-009, ACA# 19 at: https://www.cms.gov/smdl/downloads/SMD11-009.pdf

Options to Address Funding Shortfalls

The Oregon Department of Human Services, Seniors and People with Disabilities (SPD) Division, has proposed a number of actions designed to reduce spending or generate revenue for the APD program. DHS proposed actions and HMA suggested options are summarized below.

DHS Proposed Options	
• Eliminate adult day services • Reduce in-home hours • Eliminate home-delivered meals • Reduce Assisted Living Facility (ALF) and in-home agency rates • Eliminate paid time off for Home Care Workers • Eliminate Home Care Worker health insurance	• Reduce APD and AAA staffing capacity • Increase licensing fees for ALFs and Residential Care Facilities (RCFs) • Limit all nursing home rates to base rate • Eliminate the nursing home provider tax exemptions

HMA Suggested Options	Savings/Revenue (Annual - for remainder of biennium 2011-2013)
Implement a 1 percent lodging tax on community-based care facilities.[8]	Between $2.3 million and $3.0 million GF generated from a 1% tax on Medicaid income to Adult Foster Care Homes, Assisted Living Facilities and Residential Care Facilities depending on provider rates and included facilities.
Impose a cap on APD Waiver enrollment.	Projected savings: $5.0 to 7.6 million GF net, after accounting for the cost of care for persons likely to enter nursing homes without access to the waiver (depending on the percent who enter a nursing home).
Impose an individual cost limit used to limit enrollment in APD Waiver to persons with a projected cost at or below this limit; a common limit is the nursing home cost.	$278,226 GF assuming 100 persons had a cost 25 percent higher than nursing home cost and entered a nursing home. Actual savings could be greater or less, depending on how many people denied access to the waiver enter a nursing home and how much their cost of care is in the nursing home.
Implement a Medication Dispensing Initiative.	$3,500 per recipient using a dispenser.
Implement the Community First Choice option (Section 1915(k) state plan amendment).	$13 million GF based on APD Waiver expenditures. The amount could be less if there is an increased demand for the CFCO compared to the state plan personal care benefit. Savings could be greater when including other HCBS waivers and state plan personal care.
Eliminate provider tax exemptions for nursing homes (with the exception of the VA facility).	$4.7 million OF.
Implement a health care provider tax on provider classes not currently subject to a health care provider tax.	Insufficient data to project savings, but typically a large amount when certain types of providers, such as prescribed drug providers, are subject to this tax.

[8] DHS has suggested this for providers of similar services serving persons with Intellectual and Developmental Disabilities (IDD).

Recent DHS Initiatives	Calculated Savings
Veterans Affairs Match (cost-avoidance)	$103,110 to $250,728 GF per 1,000 Veterans accessing VA health care benefits. Unable to estimate impact from access to VA long-term care benefits.
Third Party Liability (TPL)	For each $10 million HMS recovers, the state nets $3.375 million. TPL recoveries are likely to be high the first year of the HMS contract. Medicaid TPL recoveries are not limited to a specific look-back period. Kansas has a look-back period of 48 months. Estate recovery is likely to exceed the current budget estimate for the biennium ending 2013 as a result of additional staffing of the Estate Recovery Unit.

The SPD Division has assessed the likely impact of their proposed actions. Therefore, our discussion is limited to the options identified by HMA and to a discussion of recent DHS initiatives that we believe will result in some cost savings or cost-avoidance specific to the SPD Division and its consumers.

Provider Taxes

Impose a 1% provider tax on community-based care facilities

Projected revenue of between $2.3 million and $3.0 million annually from a 1% tax on Medicaid income to Adult Foster Care Homes, Assisted Living Facilities and Residential Care Facilities

Remove the provider tax exemption for nursing homes

Provider tax collections could be increased by an estimated $4.7 million OF if all exemptions were eliminated (except for the Oregon Veterans' Home)

Background

A state may impose a health care tax on 18 provider classes in order to draw down federal funds through Medicaid. [See 42 CFR 433.56.] The provider classes are:

- Ambulatory Surgical Centers
- Chiropractic Services
- Dental Services
- Emergency Ambulance Services
- Home Health Care Services
- ICF/DD
- Inpatient Hospital Services
- Laboratory and X-Ray Services
- MCOs (including HMOs and PPOs)
- Nursing Facility Services
- Nursing Services
- Optometric/Optician Services
- Outpatient Hospital Services
- Outpatient Prescription Drugs
- Physician Services
- Podiatric Services
- Psychological Services
- Therapist Services

A state may also tax providers who are required to pay a fee for licensing or certification.

Provider taxes allow a state to reduce the amount of general funds needed to fund Medicaid programs and to provide provider rate increases that could not be funded with general state revenue. States routinely use provider taxes to fund portions of their Medicaid program, most commonly by taxing hospitals, nursing homes, and managed care organizations (MCOs). In 2011, 48 states have at least one provider tax, the most common being a nursing home tax (in 41 states).[9] (See Table A-14 in the Appendices.)

[9] Smith, Vernon K., Ph.D., Kathleen Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder. "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012." Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. Oct. 2011. Web. 1 Dec. 2011.

Section 1903(w) of the Social Security Act (PL 102-234 and 42 CFR 433.50, et seq.) requires that state health care-related taxes:

- Be imposed on a permissible class of health care services.
- Be broad-based or apply to all providers within a class (this requirement prohibits states from limiting the provider tax to only Medicaid providers).
- Be uniform, such that all providers within a class must be taxed at the same rate (this requirement prohibits, absent a waiver, varying tax rates based upon volume, type of services, or any other variable).
- Avoid hold harmless arrangements in which collected taxes are returned directly or indirectly to taxpayers.

A waiver of the requirements regarding the permissible class of health care services and hold harmless requirements is not permitted. States may obtain a waiver from the broad-based and uniformity requirements. To obtain a waiver, states must perform a specific waiver test for each class of health care item or service that the state taxes to demonstrate that the provider tax generally derives revenue from non-Medicaid services.

A provider tax may not exceed 6 percent of that industry's revenue. The typical approach to assessing provider taxes is as a percentage of the provider's total revenue, net revenue, or another calculation that is revenue-based.

Oregon currently has four healthcare provider taxes:

Healthcare Class	Oregon Provider Tax Rate
Inpatient Hospital Services	2.32 percent of all revenue
MCOs (including HMOs and PPOs)	1 percent of gross premiums
Nursing Facility Services	6 percent of all revenue
Outpatient Hospital Services	2.32 percent of all revenue

The current Oregon Long Term Care (LTC) Facility tax is already set at the federal maximum of 6 percent of nursing home revenue. (Oregon has no ICFs/DD, which might otherwise be included in this type of tax.) However, the state could eliminate some exemptions to the LTC Facility tax that it now allows.

The LTC Facility tax applies to all long-term care facilities except the Oregon Veterans' Home, Continuing Care Retirement Communities, and those with high (85 percent and above) Medicaid census levels.[10]

In all, 15 nursing homes (unassociated with a Continuing Care Retirement Community) are exempt from paying provider taxes on nursing facility services. [11]

[10] Kelley-Siel, Erinn, and Eric Luther Moore. "Seniors and People with Disabilities." SPD Presentation to Oregon Ways and Means Committee. 22 Mar. 2011.Web. 1 Dec. 2011.
[11] "DRAFT 2011-13 Legislative Fiscal Office requested 10.5% Reduction Options based on 2011-13 Legislatively Adopted Budget Level." 14 Nov. 2011. Web. 1 Dec. 2011.

The 2011-13 APD budget anticipated $83.6 million in nursing home provider taxes.[12] Provider tax collections could be increased by an estimated $4.7million in Other Funds if all facility exemptions were eliminated (with the exception of the Oregon Veterans' Home).[13]

Tax on Additional Classes or Types of Providers

The state could also impose a provider tax on additional provider classes and use the revenue generated by this tax to fund a portion of the LTC general fund. [14]

Other classes of providers that could be included are:

- Ambulatory Surgical Centers
- Chiropractic Services
- Nursing Services
- Dental Services
- Optometric/Optician Services
- Emergency Ambulance Services
- Outpatient Hospital Services
- Home Health Care Services
- Outpatient Prescribed Drugs
- Physician Services
- Podiatric Services
- Laboratory and X-Ray Services
- Psychological Services
- Therapist Services

Providers that incur a fee for licensure or certification by the state could also be included in a provider tax. Imposition of new provider taxes will require enabling legislation. CMS approval of a provider tax is not a requirement for implementation of a tax. However, CMS can become involved in evaluation of the legitimacy of the tax for access to federal matching funds when reviewing Medicaid state plan amendments related to use of revenue derived from new provider taxes (such as proposed rate changes). Providers are likely to oppose new taxes, but opposition might be reduced if the taxes are an alternative to rate cuts.

Table 2 displays examples of states that have imposed taxes on other classes and types of health care providers and the actual or projected revenue for states that make this information readily available.

Table 1: "Other" Health Care Provider Taxes

State	Home Care Services	Outpatient Prescribed Drugs	Ambulatory Surgical Centers	Other
Alabama		X		
Kentucky	X			Providers of services for persons with IDD
Louisiana		X		Medical Transportation
Maine				Residential Care and Day Habilitation Services 5.5% annual revenue
Michigan				Community Mental Health Services

[12] Kelley-Siel, Erinn, and Eric Luther Moore. "Seniors and People with Disabilities." SPD Presentation to Oregon Ways and Means Committee. 22 Mar. 2011.Web. 1 Dec. 2011.

[13] Hansen, Hunter and Co. January 11. 2012.

[14] "National Conference of State Legislatures." Health Care Provider and Industry Taxes/Fees. 10 Nov. 2011. Web. 28 Nov. 2011.

State	Home Care Services	Outpatient Prescribed Drugs	Ambulatory Surgical Centers	Other
Minnesota		X	X	
Mississippi				Psychiatric Residential Treatment Facilities
Missouri		X[15] Est. FY 2011 $88.4 M[16]		
New York	X $14.2 M FY 2010 $16 M FY 2011			
Utah				Rural Health Care Facilities
Vermont	X	X		Dental Tax enacted for FY 2012 0.8%[17]
West Virginia			X	Lab and x-ray
Wisconsin			X $22 M FYs 2010, 2011	

Source: National Conference of State Legislatures. Health Care Provider and Industry Taxes/Fees. Web page. Updated February 2011. Material added November 10, 2011. Accessed November 28, 2011 at: http://www.ncsl.org/?tabid=14359

Non-Health Care-Related Tax Alternatives

Some states have utilized an alternative, non-health care-related tax structure to generate revenue for their Medicaid program. Regulations that govern health-related taxes *do not apply* if:

- The tax does not substantially apply to health care providers (less than 85 percent of the taxpayers are individuals or entities providing or paying for health care items or services).
- Individuals or entities providing or paying for health care items or services are treated the same as other taxpayers. [42 CFR 433.55(b)and (c)]

Oregon is limited in its capacity to use this approach as a state with no sales tax, a tax used for this purpose by a number of states. However, Oregon's lodging and income taxes could be leveraged to generate increased revenue. Of these two options, the lodging tax seems feasible.

Not-for-Profit Corporate Income Tax

Generally, not-for-profit organizations are exempted from paying state corporate taxes. A state could choose to tax not-for-profit corporations as a method to generate additional revenue. However, this ac-

[15] "MO HealthNet Medicaid Pharmacy Report." *PowerPoint Presentation.* The Lewin Group, 16 Nov. 2009. Web. 1 Dec. 2011. This tax is used to enhance the pharmacy dispensing fee.
[16] "Fiscal Note – Senate Bill 1056." 10 Mar. 2010. Web. 1 Dec. 2011.
[17] Soderlund, Kelly. "Vermont legislature rejects dental tax." American Dental Association. 9 May 2011. Web. 19 Dec. 2011.

tion would be highly unpopular and is probably not feasible. For-profit health care entities already pay this tax, based upon federal taxes owed. Not-for-profit entities, including not-for-profit health care entities, are exempt from federal income taxes. Imposition of a state tax on not-for-profit corporations would require statutory changes and a method for determining taxable income for these entities, which could be administratively difficult.

Lodging Tax Options

The SPD Division has proposed imposing a lodging tax on certain providers of residential services for persons with Intellectual and Developmental Disabilities (IDD) at 1.0 percent of revenue. Similarly, a lodging tax could be assessed on providers of any service that includes an overnight stay. Between $2.3 million and $3.0 million could be generated annually from a 1% tax on Medicaid income to Adult Foster Care Homes, Assisted Living Facilities and Residential Care Facilities.[18]

Existing regulations exempt certain types of facilities from this tax:[19]

- Health care facilities certified, licensed or registered by the Department of Human Services
- Drug and alcohol abuse and mental health treatment facilities
- All dwelling units during the time a federal instrumentality pays for use of the units
- Dwelling units at a non-profit facility
- Dwelling units occupied by the same person for a consecutive period of 30 days or more during the year

The CMS rule currently requires that all taxpayers be treated the same. Health care providers paying the tax must do so in the same manner as all other taxpayers. However, it is possible to extend a non-health care tax to Medicaid services only and not to other services. California implemented a gross premium tax that only taxes Medicaid managed care organizations and that tax remains in place today. However, extending this tax to all services would raise more revenue and fewer concerns from CMS.

Extension of the tax to other providers would require legislative action to revise existing exemptions. CMS does not normally review non-health care related taxes. However, the state should share this tax information with CMS. Any Medicaid rate changes made to pay for the increased cost of the tax would be subject to CMS review.

CMS has drafted regulations to modify the rules that govern non-health care taxes. These rules are currently being held by the Office of Management and Budget (OMB) in the federal government but could be released at any time.

[18] Medicaid revenue amounts provided by the Oregon Health Care Association.
[19] OAR 150-320.308 State Lodging Tax Exemptions.

APD Waiver Changes

Impose a "hard cap" on the APD waiver
Projected savings: $5.0 million to $7.6 million GF annually net, after accounting for the cost of care for persons likely to enter nursing homes without access to the waiver (varying by the percent who enter a nursing home).

Limit waiver enrollment to persons whose projected cost of care is less than the institutional cost
$1.1 million annually, although actual savings could be greater or less, depending on how many people denied access to the waiver enter a nursing and how much their cost of care is in the nursing home.

It is likely that CMS will consider the imposition of a cap on enrollment or an institutional cost limit as restricting Medicaid eligibility. Therefore, this change could only be implemented:

- During waiver renewal (not until 2017).
- When Medicaid Maintenance of Effort (MOE) requirements for adults end January 2014.
- If the state terminates the waiver and subsequently develops a new waiver (and CMS could still determine that this action violated MOE requirements).
- If CMS grants Oregon additional flexibility due to its budgetary problems.

Background

States have the option to:

- Limit the number of slots available under a HCBS waiver
- Limit entrance to the waiver to those persons whose annual cost of care is projected to be less than an amount specified by the state (often the institutional cost)

In 2009, 36 states imposed some type of cost limit in one or more of their HCBS waivers (including Oregon) and twenty states set service limits.

There are reportedly eleven states without waiting lists for one or more of their HCBS waivers in 2010.

At present, the APD Waiver is operated as an entitlement. Consumers who meet the APD Waiver eligibility requirements may be enrolled into the waiver as an alternative to nursing home placement. There is no requirement that an APD Waiver applicant have a projected cost of care less than or equal to institutional cost in order to be enrolled into the waiver. However, once a person is enrolled into the waiver, their total continuing cost of waiver services may not exceed the comparable nursing facility rate except under specific circumstances and subject to the SPD Division's review and approval.

DHS specifies the number of slots annually for the APD Waiver because CMS requires that states do so in order to estimate total expenditures and, most importantly to CMS, the federal share of expenditures.

Impact

It is exceedingly difficult to project how many people would enter a nursing home if DHS placed a cap on waiver enrollment or started imposing a prospective cost limit on waiver enrollment. Several years ago, California did a study of what happened to people on its waiting list for one of its waivers and found that a very small percentage of the people on their waiting list went into nursing facilities during the time they were on the waiting list, in some cases up to a year. It is unlikely that everyone who did not have access to the waiver because the waiver slots were filled, or because they had a projected cost of care equal to or greater than nursing home care, would actually enter a nursing home. Realistically, however, a portion would do so—most likely persons who newly enter the waiver and a community-based residential care setting. New waiver enrollees residing in licensed residential settings would be more likely to enter a nursing home absent access to the waiver than persons remaining at home (although some persons at home might also enter a nursing home absent waiver services).

HMA estimated an annual financial impact to DHS for two options:

- A freeze to APD Waiver enrollment.
- Imposition of an individual cost limit as a condition of enrollment into the waiver.

Methodology

HMA used data from the APD Waiver approved application (effective date of January 1, 2012) to estimate the impact of the two options. The projected caseload growth in 2013 is 1,333 persons. (See Table 3.)

Table 2: APD Waiver Projected Enrollment, 2012-2016

	Total Waiver Enrollment	Change in Waiver Enrollment
APD Waiver Renewal Year 1 (2012)	29,940	NA
APD Waiver Renewal Year 1 (2013)	29,628	1,333
APD Waiver Renewal Year 1 (2014)	29,891	831
APD Waiver Renewal Year 1 (2015)	29,864	-27
APD Waiver Renewal Year 1 (2016)	29,835	-29

Freezing APD Waiver Enrollment

The following assumptions were used to project the potential budget impact from freezing the waiver for 2013 (for one year):

- 1,333 persons would have been enrolled in the waiver if it had not been frozen.
- 50 percent of these persons would have entered a community-based care facility (residential clients) when enrolled in the waiver. (Currently, half of all waiver enrollees live in community care facilities and half at home).
- Persons who would have lived in a community care facility are more likely to enter a nursing home without access to the waiver. (However, there are also likely some persons living at home

who would enter a nursing home if waiver enrollment were frozen who would not have first entered a residential care setting and who are not included in this calculation.)

- There is no reliable method to project how many persons would enter a nursing home if the APD Waiver were frozen. Therefore, three scenarios are presented that present cost savings when 50 percent, 25 percent and 10 percent of residential care clients enter a nursing home absent access to the APD Waiver.
- The average client cost in the waiver and in the nursing home is the amount specified in Year 1 of the APD Waiver application, (which includes the cost of all Medicaid services).

Table 3: Annual Savings to State Year 1 from Freezing Waiver Enrollment if 50% of Likely Residential Clients Enter Nursing Homes

	Value	Reference
Average Waiver Client Cost (From Approved APD Waiver Renewal)	$20,602	A
Average Nursing Home Client Cost (From Approved APD Waiver Renewal)	$30,013	B
Average Number of New Waiver In-Home Care Clients (Historic Distribution of 2011-2012 Projected Enrollment)	523	C
Average Number of New Waiver Residential Care Clients (Historic Distribution of 2011-2012 Projected Enrollment)	523	D
Total Cost of Care for Residential Clients if They Had Been in Waiver Not Entering a Nursing Home (A*D)	$10,778,280	E
Total Cost of Care for Clients if 50% Instead Enter a Nursing Home (D*0.5)*(B)	$7,850,901	F
Savings when 50% of Residential Care Clients Enter Nursing Homes (G-F)	$2,927,379	G
Cost Saved from In-Home Clients Not in Waiver or Nursing Home (C*A)	$10,778,280	H
Cost/Savings to State From Capping Waiver Enrollment (H+I)	$13,705,659	I
Federal Matching Rate FY 2012	62.91%	J
Federal Portion (K*J)	$8,622,230	K
State Portion (I-K)	**$5,083,429**	**L**

Table 4: Annual Savings to State Year 1 from Freezing Waiver Enrollment if 25% of Likely Residential Clients Enter Nursing Homes

	Value	Reference
Average Waiver Client Cost (From Approved APD Waiver Renewal)	$20,602	A
Average Nursing Home Client Cost (From Approved APD Waiver Renewal)	$30,013	B
Average Number of New Waiver In-Home Care Clients (Historic Distribution of 2011-2012 Projected Enrollment)	523	C
Average Number of New Waiver Residential Care Clients (Historic Distribution of 2011-2012 Projected Enrollment)	523	D
Total Cost of Care for Residential Clients if They Had Been in Waiver Not Entering a Nursing Home (A*D)	$10,778,280	E
Total Cost of Care for Clients if 25% Instead Enter a Nursing Home (D*0.25)*(B)	$3,925,450	F
Savings when 50% of Residential Care Clients Enter Nursing Homes (G-F)	$6,852,829	G
Cost Saved from In-Home Clients Not in Waiver or Nursing Home (C*A)	$10,778,280	H
Cost/Savings to State From Capping Waiver Enrollment (H+I)	$17,631,109	I
Federal Matching Rate FY 2012	62.91%	J
Federal Portion (K*J)	$11,091,731	K
State Portion (I-K)	**$6,539,378**	**L**

Table 5: Annual Savings to State Year 1 from Freezing Waiver Enrollment if 10% of Likely Residential Clients Enter Nursing Homes

	Value	Reference
Average Waiver Client Cost (From Approved APD Waiver Renewal)	$20,602	A
Average Nursing Home Client Cost (From Approved APD Waiver Renewal)	$30,013	B
Average Number of New Waiver In-Home Care Clients (Historic Distribution of 2011-2012 Projected Enrollment)	541	C
Average Number of New Waiver Residential Care Clients (Historic Distribution of 2011-2012 Projected Enrollment)	541	D
Total Cost of Care for Residential Clients if They Had Been in Waiver Not Entering a Nursing Home (A*D)	$11,145,682	E
Total Cost of Care for Clients if 10% Instead Enter a Nursing Home (D*0.25)*(B)	$1,623,703	F
Savings when 10% of Residential Care Clients Enter Nursing Homes (G-F)	$9,521,979	G
Cost Saved from In-Home Clients Not in Waiver or Nursing Home (C*A)	$11,145,682	H
Cost/Savings to State From Capping Waiver Enrollment (H+I)	$20,667,661	I
Federal Matching Rate FY 2012	62.91%	J
Federal Portion (K*J)	$13,002,025	K
State Portion (I-K)	**$7,665,635**	**L**

The greater the number of persons entering a nursing home, the smaller the net savings from freezing enrollment.

It is unlikely 50 percent of persons who would have enrolled into the APD Waiver and resided in a community-based care facility (or 25 percent of all potential waiver enrollees) would enter a nursing home in year 1. The more likely scenario is that somewhere between 10 and 25 percent of persons who would have enrolled into the APD Waiver and resided in a community-based care facility (or between 5 and 12.5 percent of all potential waiver enrollees) would do so. However, as time passes, the likelihood that any person in need of LTSS who has no source of coverage for these services will enter a nursing home increases. Therefore, the longer the waiver is frozen, the greater the chance that an increasing proportion of persons needing access to the waiver would enter nursing homes.

Note that there would also likely be an increase in state plan personal care use absent access to waiver services. In September 2011, 943 SPDs utilized SPPC (just under 10 percent of all SPD Division in-home hourly care users and just over 3 percent of all SPD LTC users). (See Table 7.) SPPC is not available to HCBS waiver or PACE enrollees or in licensed residential settings and is limited to 20 hours monthly.

SPD Division clients most likely use SPPC when they do not need access to additional waiver services, when they are not eligible for the waiver, or when they are in a period of transition from a hospital or nursing home to the waiver (prior to waiver enrollment). SPPC use would undoubtedly increase as persons who would have had access to waiver services prior to implementation of a cap remain at home and on a waiver waiting list.

Table 6: State Plan Personal Care Caseload September 2011

September 2011 SPD Caseload	Count
All Long-Term Care (LTC)	28,222
In-Home Hourly Care	9,558
SPPC	943
SPPC as a % of All LTC	3%
SPPC as a % of All In-Home Hourly Care	10%

Source: Forecasting, Research and Analysis. Monthly Forecast Update Department of Human Services: Seniors and People with Disabilities Aged and Physically Disabled. October 2011.

Imposing a Cost Cap as a Condition of APD Waiver Enrollment

If SPD imposed a prospective cost cap on the APD Waiver, limiting enrollment to SPD consumers with a cost of care equal to or less than the average SPD nursing home cost of care, we project that about 100 people a year would be denied entrance to the waiver, (utilizing claims data from SPD and assuming new waiver enrollees had similar needs to current enrollees).

Table 7: Estimate of Impact of Imposing APD Waiver Prospective Cost Cap

	Number	Refer-ence
Total APD Waiver Enrollees	29,940	A
% of APD Waiver Enrollees with Cost In Excess of Nursing Home Cost FY 2011 (B/A)	7.50%	C
Average Annual Waiver New Enrollees	1,333	D
Waiver New Enrollees with Cost In Excess of Nursing Home Cost (D*C)	100	E
Total Cost of Care in a Nursing Home (F* $30,013)	$3,000,550	F
Total Cost of Care in Waiver if Waiver Cost is 25% Higher Than NF Cost	$3,750,688	G
Savings if Waiver Cost is 25% Higher Than NF Cost	$750,138	H
Federal Matching Rate FY 2012	62.91%	I
Federal Portion (H*I)	$471,912	J
State Portion (H-J)	$278,226	K

If all 100 persons who would be denied entrance to the waiver because their cost of care was higher than the average nursing home cost instead entered a nursing home, and their waiver cost of care was 25 percent higher than the average nursing home cost, the potential savings to the state would be $278, 226 a year. This assumes each of these 100 persons would enter a nursing home and that the nursing home cost would be the same for each person. It is certainly possible that not everyone would enter a nursing home or that some who did enter would cost more than the average nursing home cost.

Third Party Liability

Medicaid is the payer of last resort for recipients' medical claims. Each state's Medicaid program is required to establish policies and practices designed to ensure that all other sources of payment from any third party are utilized before Medicaid. Examples of third parties which may be liable to pay for services include group health plans, Medicare, court-ordered health coverage, settlements from a liability insurer, workers' compensation, first party probate-estate recoveries, long-term care insurance, and other state and federal programs (unless specifically excluded by Federal statute).

States have various options in implementing Third Party Liability (TPL) review and collections, from performing this work with state staff or contracting with private firms that specialize in recovering TPL claims on behalf of the state. However, TPL collections for members enrolled in managed care plans are typically the responsibility of the plan, and capitation rates are adjusted based on projected TPL collections by the managed care plan.

The majority of Medicaid enrollees in Oregon are enrolled in managed care plans. Oregon's capitated rate service costs are adjusted downward to account for anticipated TPL recoveries for the fully capitated health plans by 0.54 percent for non-dual eligibility categories. No TPL adjustment is applied to the mental health-only or dental care plans.[20]

Recently, the state of Oregon entered into a contingency contract with Health Management Services (HMS) effective until September 14, 2014, to audit provider claims and identify overpayments. Activities include inpatient claims review, outpatient claims review, professional claims review, and TPL identification and recovery reviews.

HMS will be paid 9 percent of the recoveries up to a maximum amount of $3.5 million under this contract for a maximum recovery amount of approximately $37.2 million. For each additional $1 million in collections that HMS makes, the Medicaid program will net $910,000. This $910,000 will be apportioned between the state and the federal government, with the state receiving 37.03 percent or $337,500.

If HMS were to recover $10 million, the state would net $3.375 million. HMS could recover a large amount during the initial period of the contract as a result of a longer, initial look-back period. For example, Kansas implemented contracted TPL recovery in 2010 and specifies a 48 month look-back period for over-payments.[21]

Estate Recovery

Estate recovery does not appear to be included in the HMS contract. In 2004, Oregon had the second highest level of estate recovery collections as a percentage of all nursing home spending at 5.8 percent

[20] "Oregon Health Plan Medicaid Demonstration. Capitation Rate Development, January 2011 – December 2011." Actuarial Service Unit Budget Planning and Analysis, Oregon Department of Health Services. 15 Oct. 2010. 11.
[21] Joshua Mast. KMAP and the RAC. Kansas Health Policy Authority. PowerPoint presentation. Retrieved 01 January. 2012.

(and the highest state, Arizona with 10.4 percent, was not comparable because nursing home recoveries are part of the managed care program and not separately identifiable from other recoveries).[22] The SPD Division reports that for the state biennium ending June 30, 2011, the DHS Office of Payment Accuracy and Recovery (OPAR) collected $38.4 million in estate recoveries. $20.1 million was used to offset General Fund expenditures in the SPD Division budget. The remainder was returned to the federal government for its share of Medicaid.

For state biennium ending June 30, 2013, OPAR has projected recoveries of $32.6 million, which will result in an estimated $17.4 million to offset State General Fund expenditures in SPD. The remainder will be returned to the federal government for its share of Medicaid. However, each recovery specialist collects $8 for every $1 invested in staff costs. DHS has recently added staff to the Estates Recovery Unit and is implementing new technology to increase recoveries. As the elderly population increases, so should the opportunity to recover costs from estates also increase.[23] It is HMA staff experience that the amount of money that can be recovered by the estate recovery program is directly related to the number of staff who can do these recoveries. Therefore, it seems likely that actual recoveries for the biennium ending 2013 should be higher than in the previous biennium rather than lower as projected.

DHS and OHA should ask HMS to also review the staffing level and practices in the Estates Recovery Unit to assure the maximum recovery through this effort and whether they could further increase recoveries in estate recovery.

[22] Department of Health & Human Services, Office of Assistant Secretary for Policy & Evaluation Policy. "Brief #6 – Medicaid Estate Recovery Collections." *Medicaid Eligibility for Long-Term Care Benefit.* Sept. 2005. 8-9.
[23] SEIU. Moving Oregon Forward 2012: An Update. January 13. 2012.

Community First Choice Option

Effective October 1, 2011, a new Medicaid state plan option to provide home and community-based attendant services and supports authorized by section 1915(k) of the Social Security Act (the Act) became available (the Community First Choice Option of CFCO). The option permits states to provide home and community-based attendant services and supports and allows states to receive a 6 percentage point increase in Federal matching payments for expenditures related to this option. States may receive this enhanced federal match for services it already provides if these services are moved to this option.

The CFCO does not create a new eligibility group. Individuals eligible under the Medicaid state plan whose income does not exceed 150 percent of the Federal Poverty Level (FPL) are eligible for the Community First Choice Option without requiring a determination of institutional level of care. Persons may qualify who have incomes above the level specified in the state plan if they meet institutional level of care requirements. Persons eligible for Medicaid through the special home and community-based services waiver eligibility group may access the CFCO only if they receive at least one home and community-based waiver service per month.

CMS published a proposed rule February 25, 2011 that provides additional details about this option. The access to an additional 6 percentage points in FMAP that is not time limited is attractive to states that operate large personal care programs or that make personal care services available through their HCBS waivers as an entitlement (such as Oregon), because they do not anticipate significant increased demand as a result of implementing this option.

California has submitted a state plan amendment to transition most Medi-Cal recipients now receiving In-Home Supportive Services (IHSS, California's Medicaid state plan personal care option) to the CFCO.

Should Oregon decide to pursue this option there are several considerations of importance:

- The CFCO may not target enrollment based on age, severity of disability, or any other criteria. Therefore, this option if implemented, absent any clarification from CMS otherwise, could not be limited to the APD Waiver enrollees.
- States must maintain expenditures for elders and persons with disabilities at the same level during the first year of implementation as in the prior year. CMS has clarified in the proposed rule that the expenditures that must be maintained are for personal care services rather than all LTSS. CMS has also received numerous comments for this rule including that states should be required to maintain the same level of HCBS rather than solely personal care services expenditures.
    - DHS reduced the amount of the general fund attributable to in-home care services in FY 2012 to 86 percent of the amount for FY 2011. Therefore, DHS would need to establish an acceptable baseline of expenditures (most likely for FY 2013) in order to implement this option.

- It is possible that additional persons would qualify for the CFCO or would find the CFCO more attractive than the existing state plan personal care benefit beyond those now eligible for or requesting state plan personal care.
- Some services provided through the APD Waiver cannot be covered by the CFCO. For example, adult day services, meals and non-medical transportation could not be included. Specifically excluded are: Assistive technology devices and assistive technology services other than those specifically included in the CFCO, medical supplies and equipment and home modifications.
- The state is required to operate an Implementation Council to guide the state's implementation of the CFCO. The members must include a majority of individuals with disabilities, elderly individuals, and their representatives.

Unlike California that is transferring recipients from one limited state plan benefit (IHSS) to another limited benefit (CFCO), Oregon might face problems gaining approval for the CFCO from CMS if it proposes to move persons from the APD Waiver and to reduce benefits as a result.

Oregon could offer CFCO services to waiver enrollees by amending the waiver to remove the similar benefits, thereby transferring them to the state plan, and providing access to the services not covered by the CFCO through the waiver. In this manner, the state could access the additional FFP and retain a modified APD Waiver. Access to waiver services is also required in order to permit persons eligible for Medicaid through the special home and community-based services waiver eligibility group to remain Medicaid eligible.

If this option was pursued, Oregon could not implement a cap or freeze enrollment in the waiver.

Since about half of all APD Waiver recipients are residing at home, the increased FFP amount would be substantial. For example, if the entire cost for in-home personal care and specialized living projected in the APD Waiver for renewal year 1 were eligible for the six percentage point increase in FMAP, the state would net an additional $13 million.

In-Home Personal Care Cost	$	225,887,800
Specialized Living Cost	$	2,691,409
Total Cost	$	228,579,209
6 percentage point increase in FMAP	$	13,714,753

Additional funds would be available if other HCBS waivers and state plan personal care service expenditures were included.

A more detailed analysis is necessary to completely and accurately cost out this option, taking into account additional costs incurred to develop and implement the CFCO and potential increased demand for the CFCO compared to the state plan personal care benefit. Nevertheless, this appears to be an opportunity worth pursuing for implementation when the state can meet the required maintenance of effort requirements for personal care.

VA Benefits

Pursue PARIS VA match for VA health benefits (non-LTC)

Cost avoidance of $278,000 to $676,000/1,000 veterans (net state and federal) = $103,110 to $250,728 state share using Oregon FMAP (2012)

Savings are net of expenses for state staff and data-related costs based on other state experience

Pursue PARIS VA match for VA LTC benefits

Cost avoidance savings unknown: some savings is possible but data is not available to estimate the savings

Military veterans are eligible for health benefits through the United States Department of Veterans Affairs (VA) but are not always aware of this eligibility or do not apply for coverage. States can achieve cost-savings by locating Medicaid-eligible veterans who have not applied for VA health coverage and assisting them with application.

In 2003, the state of Washington initiated a VA project and joined a multi-state consortium to utilize PARIS—the Public Assistance Reporting Information System—to connect records of the Department of Defense (DOD), VA, other states, and the Washington Medicaid client eligibility computerized system. Information accessed through PARIS allows the user to research veterans' records to determine their level of eligibility for VA benefits. As a result of this records matching, Washington reports Medicaid cost-savings by year of:

- FY06 - $3,015,914
- FY07 - $3,296,187
- FY08 - $3,815,530
- FY09 - $4,856,885
- FY10 - $4,389,603[24]

Effective October 1, 2009, all States were required to sign an agreement to participate in PARIS as a condition of receiving Medicaid funding for automated data systems (including the Medicaid Management Information System).

Oregon DHS staff report that the state is in the process of implementing VA data matches statewide. Staff also report an initial review of matches did not identify significant potential VA benefit sign-ups. However, the VA has implemented a new data system (Vet Link) that should result in improved matching and that will produce the first new report for Oregon in December with complete data. State staff al-

[24] "ACF: Success Stories and Examples of Savings using PARIS." Department of Health and Human Services. Web. 8 Nov. 2011.

so believes that savings will not accrue until at least mid-2012 and possibly later for several reasons, including:

- Length of time to qualify for VA benefits—the VA benefit approval process can take up to a year.
- The level of savings is uncertain. Some states do a better job than others with up-front program matching. It is possible that Oregon will be different from other states if benefit workers are doing a good job of screening for VA benefits and helping Medicaid applicants submit applications for VA benefits.
- Veterans in Oregon may be different in terms of VA program eligibility from Veterans in states like Washington that have achieved substantial savings.

Nevertheless, some level of savings is likely to be achieved.

A study by the Altarum Institute published in 2008 examined the extent to which financial savings could accrue to state agencies participating in PARIS if they were to take full advantage of its potential.[25] The VA matching capabilities of PARIS provide the state with:

- Verification of VA income, including the amount and type of VA income a veteran is receiving
- Verification of eligibility for Federal military insurance (TRICARE) and for other VA benefits, including long-term care benefits

Verification of VA Income

Verification of VA income will result in a portion of Veterans becoming ineligible for Medicaid who had unreported or underreported income. Altarum examined savings in three states conducting VA matches and their net savings, and annualized these savings. Table 9 displays annualized savings estimates for Medicaid clients who had under/unreported VA income, according to the August 2008 match file from the Altarum Institute report. [26]

Table 8: Annualized Estimates of Savings in Three States from Verification of VA Income, Altarum Study

State	Number of clients referred for follow-up	Number of cases for which benefits were closed (2.4%)	Improper payment avoidance	Cost	Net	Net Per Case
CO	2,031	49	$99,372	$67,658	$31,714	$647.22
ME	2,420	58	$96,744	$80,616	$16,128	$278.07
NM	875	21	$43,344	$29,148	$14,196	$676.00

[25] "Public Assistance Reporting Information System Cost-Benefit Analysis – Final Report." Altarum Institute. 2008. Web. 1 Dec. 2011.
[26] Ibid.

Table 9: Savings Per 1,000 Cases Applying Savings from Examples in Table 9

State	Annualized Net Savings Per 1,000 Cases
CO	$647,224
ME	$278,069
NM	$676,000

Identifying Eligibility for VA Long-Term Care Benefits

The Altarum Institute also examined the potential for identification of veterans who may have long-term care benefits available through the VA. Table 11 displays data for those veterans who were rated as 70 percent to 100 percent disabled, Medicaid eligible and residing in a long-term care setting. The percentage is small but could provide additional cost savings. Because of limited state experience pursuing Veterans long-term care benefits, cost savings were not estimated by Altarum. [27]

Table 10: States Reporting Veteran 70 Percent or More Disability Status

State	Number of clients receiving income from the VA	Number of Veterans rated 70-100% disabled	Number of Veterans rated 70-100% disabled AND who are enrolled in Medicaid	Estimated number of Veterans rated 70-100% disabled AND who are enrolled in Medicaid AND living in LTC facility
	N	N (%)	N (%)	N
CO	3,306	44 (1.3)	11 (0.30)	4
KS	1,818*	--	6 (0.33)	2
ME	2,474	53 (2.1)	--	8
NM	1,408	28 (2.0)	23 (1.3)	8
Average	--	1.7%	0.8%	--

[27] Ibid.

Medication Dispenser Initiative

If just $3,500 annually in health care cost savings resulting from use of the medication dispensers were achieved for each of 3,500 DHS clients, the total annual savings would be $12.5 million TF or $4.5 million in GF.

As part of the California 2011–12 budget, the California Legislature established a medication dispensing pilot program intended to improve medication compliance among Medicaid recipients. The initiative projects an annual net cost avoidance of $140 million from reduced nursing home placement and hospital admissions.

Automated medication dispensing machines with monitoring and reporting capability typically include the following features:[28]

- Pills are manually loaded into the machine, usually by a formal or informal caregiver.
- At the programmed dosing time, the machine provides a visual or auditory alert to the individual and presents the medications to be taken.
- If the medications are not taken within 60 to 90 minutes, the pills are retracted (like a drawer closing), and up to five caregivers are notified.

Reminders can also be programmed into the machines for non-pill medications, such as insulin and other injectables, topical or inhaler medications.

Budget legislation requires the California Department of Finance (DOF) to report to the Legislature by April 10, 2012, on how much savings the pilot is likely to achieve. At that time, the Legislature will have until July 1, 2012, to enact alternative legislation to achieve a total of $140 million in ongoing savings from the medication pilot and/or new initiatives. If the DOF determines that these legislative actions are insufficient to achieve $140 million in savings, an across–the–board reduction in California's personal care services program hours sufficient to meet this savings target will be implemented in 2012–13. The forecast assumes that no savings from the medication dispensing pilot will be achieved in 2011–12 but that the full $140 million target will be achieved beginning in 2012–13. California will need to achieve a savings of $3,500 per recipient for 40,000 recipients to reach the target savings.

Oregon could implement a similar pilot project with or without a guaranteed savings requirement. If just $3,500 annually in health care cost savings resulting from use of the medication dispensers were achieved for each of 3,500 DHS clients, the total annual savings would be $12.5 million or $4.5 million in state funds. The pilot could target high-risk and high-cost clients residing at home; it is likely to benefit anyone who has a complicated drug regimen, a history of medication non-compliance, or some level of cognitive impairment that may make it difficult to remember when and which medications to take.

[28] Center for Technology and Aging. "California Senate Bill 72: Considerations for Implementing a Successful Medication Dispensing Machine Pilot Project." *Policy Brief*. Spring 2011. Web. 1 Dec. 2011.

Other Options

Explore the potential to move any portion of room and board costs that reflect "service" expenditures into the waiver service and access FFP: Room and board cannot be matched through the waiver. However, if any activities by residential providers represent a "service" that could be covered under the waiver, these costs could be added to the existing waiver service to access additional FFP.

Permit family members to supplement the room and board payment: A cost savings is not attached to this option because it is difficult to determine with any certainty the extent to which DHS might be accruing increased costs from SPDs who are unable to access a residential setting and enter a nursing home. However, it is likely that some recipients end up in such a situation when the combination of in-home services and family supports are no longer adequate to maintain the person safely at home.

Assisted Living/Residential Care Facility Services

In Oregon, APD Waiver enrollees residing in an ALF or RCF pay their room and board cost directly to the facility. The amount paid is specified by the SPD Division based on the maximum Supplemental Security Income (SSI) payment amount and includes an amount that clients may keep for their personal allowance. The amount paid by the waiver enrollee for those enrollees who receive a monthly SSI check is displayed below (using the maximum SSI benefit amount):

Calendar Year 2011		
Maximum SSI Payment	$ 674.00	<--- Increasing to $698 in CY2012
Less: Personal Allowance	$ 150.30	<--- Increasing to $155.30 in CY2012
Less: Room and Board	$ 523.70	<--- Increasing to $542.70 in CY2012
Equals: Excess Income	$ 0	

The room and board amount paid by a waiver enrollee for those enrollees who receive more than the monthly SSI maximum benefit amount is the same as for an enrollee with lower income. The example below shows a client with $1,000 in monthly income, who as a result has excess income of $326 a month:

Calendar Year 2011		
Income	$ 1,000.00	
Less: Personal Allowance	$ 150.30	
Less: Room and Board	$ 523.70	
Excess Income	$ 326.00	<-- Amount can be reduced by incurring qualifying expenses such as medical expenses

Any excess income must be contributed to the cost of waiver services. The SPD Division subtracts the client's excess income from the monthly payment made to the residential provider. The clients are responsible for paying their excess income to the residential provider.

Calendar Year 2011	**Situation 1**	**Situation 2**	
APD Waiver Service Rate	$2,000.00	$ 2,000.00	
Less: Client Liability	$ -	$ (326.00)	<--- Paid directly to facility by client
Equals: State Payment	$ 2,000.00	$1,674.00	
General Fund Portion	$ 746.00	$ 624.40	
Federal Fund Portion	$ 1,254.00	$ 1,049.60	
Total Income Received by Provider	$ 2,523.70	$ 2,523.70	

Oregon includes a broad service description for residential providers in the APD Waiver:[29]

- Assisted Living Facilities [services]: Supervision and assistance to support individual health, activities of daily living or instrumental activities of daily living—coordinated or provided as needed in support of individual preferences and comfort in fully self-contained private living settings. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Services are provided in conjunction with residing in the facility. Routines of care provision and service delivery are consumer-driven to the maximum extent possible. Services do not include 24-hour skilled care or supervision.
- Residential care Facilities [services]: Supervision and assistance 24-hours/day to support individual health, activities of daily living and instrumental activities of daily living. Services are provided in shared or individual living units where six or more seniors or adults with disabilities may reside. Services address personal assistance, health and social needs in ways that promote choice, dignity, individuality and independence. Room and board costs are not included in waiver services.

There is a possibility, although it is likely quite small, that residential providers are performing a service or task that is captured in the room and board payment that could be transferred to the waiver services cost (and thereby access additional FFP).

We cannot determine the extent to which this might exist. The amount of the room and board set by the SPD Division does not appear to be based on any specific facility cost information but is instead set based on affordability for waiver enrollees. We suggest that the SPD Division meet with residential providers participating in the APD Waiver to determine if there is any opportunity in this area.

[29] "Application for a §1915 (c) HCBS Waiver HCBS Waiver Application Version 3.3" Oregon Department of Human Services (DHS), 29 Jun. 2006. Web. 1 Dec. 2011.

Assisted Living/Residential Care Facility Supplement

The SPD Division has previously (in 2008 and 2009) reported a lack of access to residential care settings, including ALFs, RCFs and AFCHs.[30] The Division proposed specific actions designed to improve access, including increasing the rates paid for services delivered in these settings, but with the exception of some COLA changes and enhanced rates for memory care, rate increases fell victim to the declining economy.

One approach that could improve access that has not been implemented in Oregon, but that is used in at least 25 other states, is to permit family members to supplement the cost of room and board in a community-based facility. Family supplementation might improve access at no or minimal cost to the state (related to rule changes and oversight). The family can contribute an amount directly to the facility or to the individual who would then pay this to the facility.

Because room and board is not reimbursable in HCBS waiver settings, this payment does not run afoul of Medicaid payment in full requirements. Note that whether the amount constitutes income or an in-kind contribution, it will be treated as income and could impact a recipient's eligibility for Medicaid as well as impact SSI payments.[31]

There are two provisions in effect in Oregon at present that would likely need to be changed to permit family supplementation:

- The SPD Division limits the amount a community-based care facility may charge a client to $523.70 monthly. [OAR 461-155-0270 Room and Board Standard; OSIPM.]
- In addition, OAR requires that individuals with excess income contribute to the cost of services pursuant to OAR 461-160-0610 and 461-160-0620. It is likely a family contribution to the individual would be treated as excess income.

New Jersey has permitted family supplementation since 2001. In November of this year, the New Jersey Department of Health and Senior Services released a policy memorandum revising protocols governing supplementation.[32] Among the requirements are:

- Supplementation shall not be a condition of admission for prospective residents.
- Medicaid payment is payment in full, excluding room and board. There may be no supplementation of services.
- The cost share liability of the waiver participant will not change due to supplementation.

[30] Toews, James. "Community-Based Care Capacity Update and Recommendations for Revitalizing Oregon's Reimbursement System. Stakeholder Forum." *PowerPoint Presentation*. Oregon Department of Human Services. 12 Dec. 2008. Web. 1 Dec. 2011. Also: "Draft: Seniors and People with Disabilities. Recommendations for Revitalizing Oregon's Community Based Care Reimbursement System. Version 4." Oregon Department of Human Services, 19 March 2009. Web. 1 Dec. 2011.

[31] Mollica, Robert L., Ed.D. "State Medicaid Reimbursement Policies and Practices in Assisted Living." National Center for Assisted Living American Health Care Association. Sept. 2009. Web. 1 Dec. 2011.

[32] "Room and Board Supplementation – Policy Memorandum." New Jersey Department of Health and Senior Services, 32.5. 10 Nov. 2011.

- The amount of supplementation is limited to the difference between the facility's published fees for the unit to which the person is being upgraded and facility's published fee submitted to Medicaid.
- Supplementation may involve any accommodation within the facility.
- The state Medicaid agency is to be informed of the supplementation.
- Providers willing to accept supplementation must complete a form "Provider Enrollment Statement of Intent to Accept Supplementation."

In Wisconsin, members enrolled in the state's managed long-term care programs (Family Care, Partnership or PACE), may be eligible for room and board supplementation by the managed care organization (MCO). In order to provide supplementation, the MCO must maintain documentation in each member's record that whenever the MCO pays more in room and board to a facility for any member than it has collected from that member, the resulting supplementation of room and board is a cost-effective substitution for institutional care for that member. This determination of cost-effectiveness must be made by an Interdisciplinary Team (IDT).[33]

HMA suggests that the SPD Division work with residential providers, consumers, family members and advocates to develop a supplementation policy designed to promote access to high-quality residential care facilities.

[33] "DLTC Numbered Memo Series 2010-05. Index Title: Family Care Member Income Calculation for Payment of Room and Board in Substitute Care." 5 Mar. 2010. Web. 1 Dec. 2011. Also, "DHS Instructions for Determining a Member's Income Available to Pay for Room and Board in Substitute Care. Appendix A - Certification of Cost-Effectiveness of Room and Board Supplementation by MCO." Web. 18 Dec. 2011.

Oregon's National Long-Term Care Status

Oregon has long been a leader in funding home and community-based care as an alternative to institutional care.

In the 1990s, Oregon was recognized as one of three states (the others being Washington and Wisconsin) that had already shifted care to the community from nursing homes, reducing the ratio of nursing home beds per 1,000 persons 65 years of age and older from 47 in 1982 to 36 in 1992.[34] This shift has continued, with Oregon having only 24 beds per 1,000 persons 65 years of age and older in 2010 compared to the national average of 42.

Oregon was recently ranked **third** among the 50 states and Washington, D.C. across four dimensions of long-term system and supports (LTSS) system performance:

- Affordability and access
- Choice of setting and provider
- Quality of life and quality of care
- Support for family caregivers.[35]

Oregon *had the lowest nursing facility occupancy rate in the nation* at 61.8% in 2010. Oregon was one of only eleven states with more Medicaid long-term care spending for HCBS than for institutional care in 2009. (See Figures A-1 and A-2, and Tables A-1 and A-2 in the Appendices for state-by-state and national data.)

3rd	Percentage of Medicaid long-term care spending on home and community-based services (HCBS[36]) for the aged and disabled (2009)[37]
2nd	Number of assisted living and residential care units per 1,000 population age 65+ (2010)
4th	Single entry point (ADRC) functionality (2009)
3rd	Number of adult consumers self-directing their services (2009)
5th	Percent of adults with disabilities reporting they usually or always get needed supports (2009)
1st	Access to caregiver supports (composite indicator)[38]
1st	Degree to which health maintenance tasks can be delegated (2011 - 1 of 4 states with this rank)

[34] "Successful State Efforts to Expand Home Services While Limiting Costs." United States General Accounting Office. Web. 1 Dec. 2011.

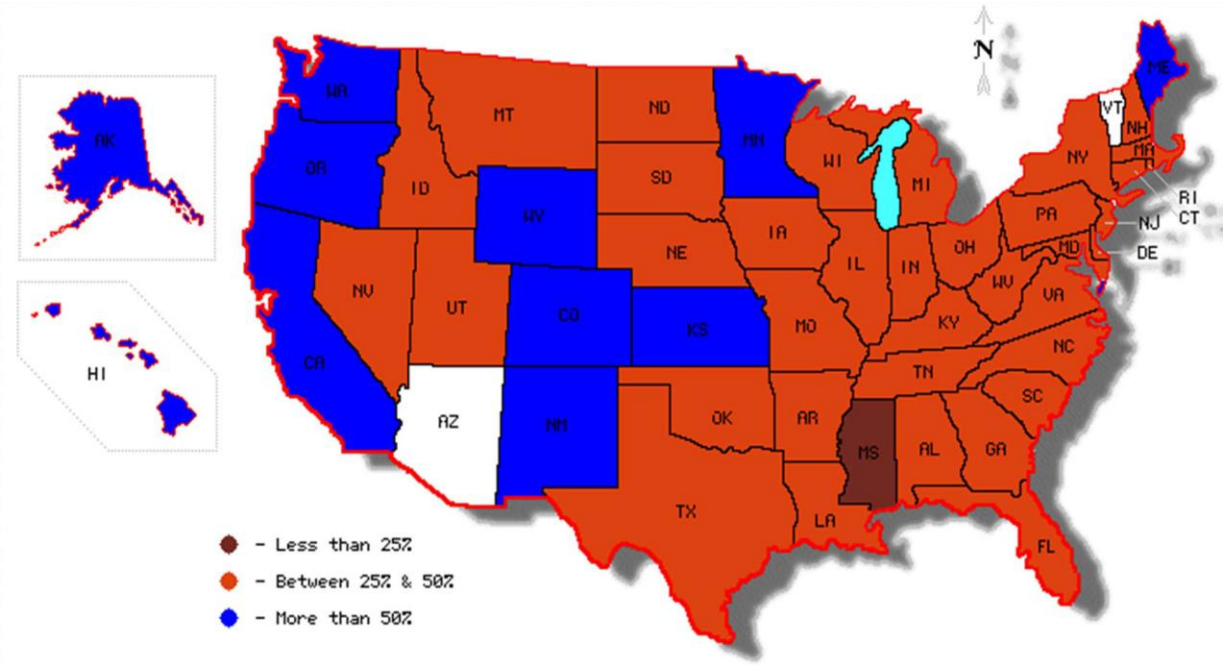
[35] Reinhard, Susan C., Enid Kassner, Ari Houser, and Robert Mollica. "Raising Expectations - A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." AARP, The Commonwealth Fund, and The Scan Foundation. Sept. 2011. Web. 1 Dec. 2011.

[36] HCBS include personal care, home health, PACE, and HCBS targeting older adults and people with physical disabilities authorized under Sections 1115, 1915(c), 1915(j), and 1929.

[37] In Oregon referred to as Seniors and People with Physical Disabilities (SPDs). Aged and Disabled (AD) is a Medicaid eligibility categorization.

[38] Access to Caregiver Supports was ranked based on three indicators: Percent of family caregivers getting needed supports (2009), state policies that exceed federal Family and Medical Leave Act (FMLA) requirements (2011), and the state's permitted number of delegated health maintenance tasks (2011). This score could be adversely impacted by DHS elimination of funding for local coordination of respite care services effective July 1, 2010.

Figure 1: States' Medicaid Expenditures for HCBS as a Percent of all Long-Term Care Expenditures (2009)



Source: Ng, J.D., M.A., Terence. The Affordable Care Act & Home and Community-Based Services. University of California, San Francisco. www.academyhealth.org/files/2011/tuesday/weissert.pdf

Demographics

Oregon's proportion of elderly and non-elderly adults in 2009 was slightly higher than the national average as shown in Figure 2. The proportion of these groups with disability, based on measures of disability in activities of daily living (ADL), was similar to but slightly higher than the United States average based on the presence of any disability. (See Figure 2.)

Figure 2: Proportion of Population 18-64 and 65 Years +, Oregon and US, 2009

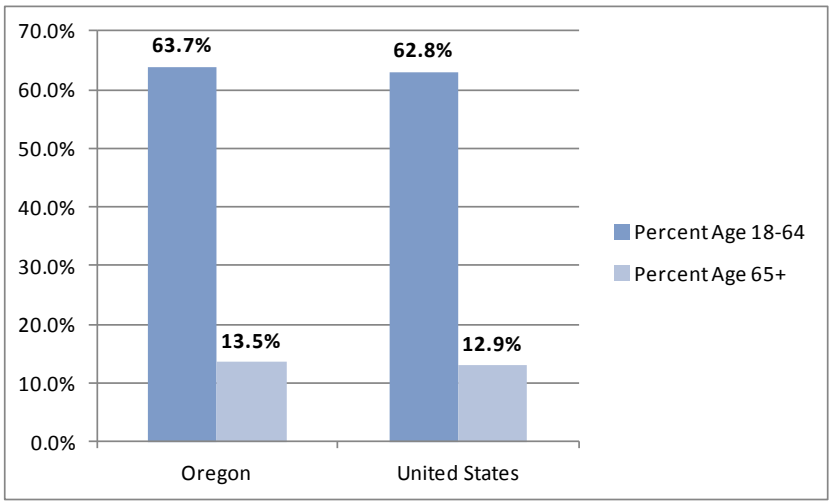
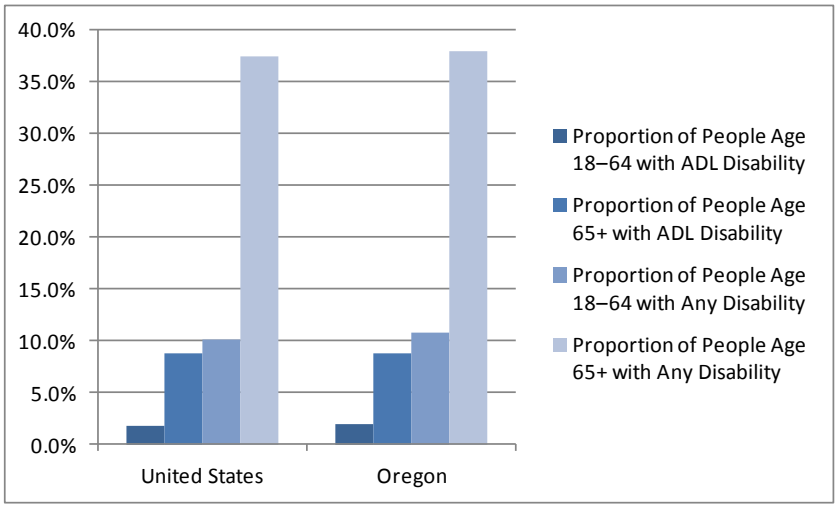


Figure 3: Proportion of Population with ADL Disability and Any Disability, 18-64 and 65 Years + Groups, Oregon and US, 2009

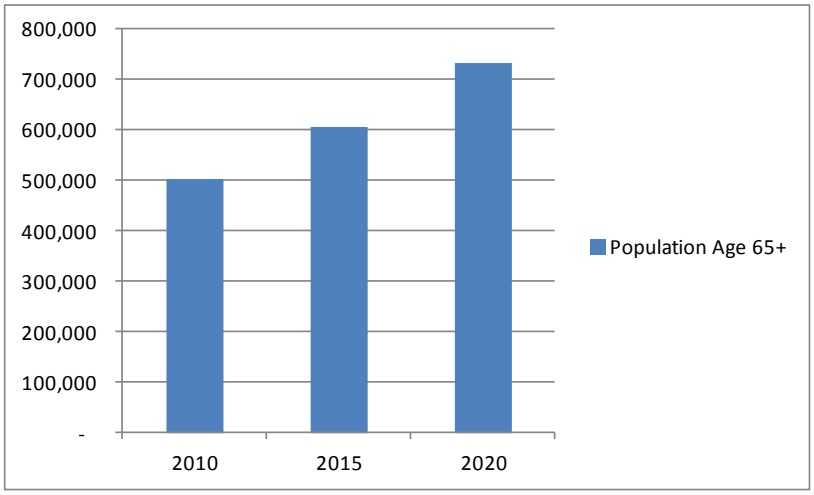


Source Figures 2 and 3: Reinhard, Susan C., Kassner, Enid, Houser, Ari, and Mollica, Robert. Raising Expectations - A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers. *September 2011.*

Proportions and rankings by state and nationally are provided in Figures A-7, A-8, and A-9 and Tables A-11, A-12 and A-13 in the Appendices.

Oregon's proportion of the population age 65 or older is projected to increase to 18.2% by 2030, moving from approximately 21st among states in 2010 to 13th by 2030.[39]

Figure 4: Projected Population Growth in Oregonians 65 Years of Age and Older, 2010 to 2020



Sources: Office of Economic Analysis, Department of Administrative Services, State of Oregon; and U.S. Census Bureau, Population Division

[39] "Proximity - State Projections. State Population Estimates and Projections, 2000-2030 -- Population Ages 65 years & Over and Percent of Total Population." Web. 1 Nov. 2011. Ranking among states varies depending on the report source.

Oregon is projected to have 733,756 residents age 65 years or older by 2020, compared to the estimated 2010 population of 501,944.[40]

The growth in the population 65 years of age and older, when analyzed by age groups, shows greater proportional growth among the "older old" and "oldest old" as the baby boomers age. (See Table 12.)

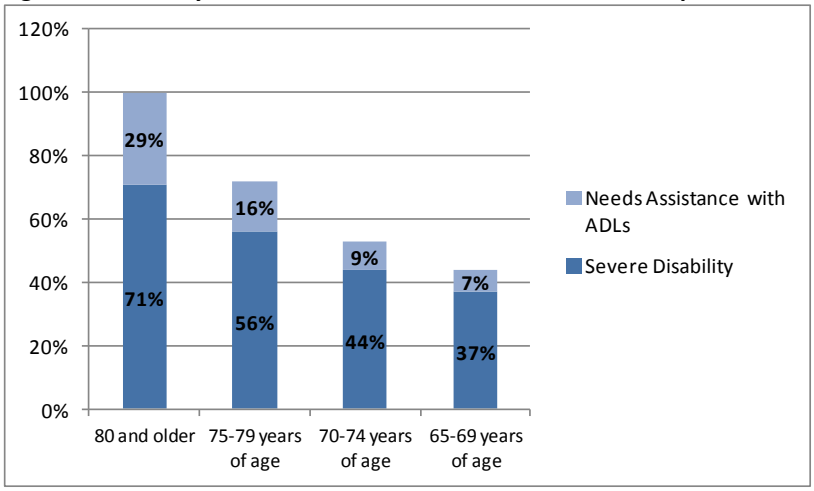
Table 11: Change in Distribution of the Total Population by Age for the United States, Oregon, 2010 to 2050

Year(s)	Percentage								
	2010	2020	Change 2010-2020	2030	Change 2020-2030	2040	Change 2030-2040	2050	Change 2040-2050
Under 20 years	27.1	26.6	-0.5	26.2	-0.4	25.8	-0.4	25.7	-0.1
20 to 64 years	59.9	57.4	-2.5	54.5	-2.9	54.2	-0.3	54.1	-0.1
65 years and over	13.0	16.1	3.1	19.3	3.2	20.0	0.7	20.2	0.2
65 to 69 years	4.0	5.2	1.2	5.5	0.3	4.7	-0.8	4.9	0.2
70 to 74 years	3.0	4.2	1.2	4.9	0.7	4.4	-0.5	4.2	-0.2
75 to 79 years	2.3	2.8	0.5	3.9	1.1	4.1	0.2	3.6	-0.5
80 to 84 years	1.8	1.8	0.0	2.7	0.9	3.3	0.6	3.1	-0.2
85 to 89 years	1.2	1.1	-0.1	1.4	0.3	2.1	0.7	2.3	0.2
90 years and over	0.7	0.8	0.1	0.9	0.1	1.4	0.5	2.0	0.6

Source: Grayson K. Vincent and Victoria A. Velkoff. United States Census Bureau. *The Next Four Decades: The Older Population in the United States: 2010 to 2050*. Population Estimates and Projections. May 2010. Appendix Table A-1. Change calculation by HMA.

This shift is significant because the rate of disability and need for assistance with ADLs increases substantially as age advances. (See Figure 5.)

Figure 5: Disability and Need for ADL Assistance in the 65+ Population for the United States, 2005



Source: Matthew W. Brault. United States Census Bureau. Household Economic Studies *Americans With Disabilities: 2005*. Issued December 2008. Based on Figure 2.

[40] "Oregon's Demographic Trends." Oregon Office of Economic Analysis, Department of Administrative Services. Feb. 2010. Web. 1 Dec. 2011.

Even though the disability rate among the 65+ population will likely continue to decline, the size of the older disabled population is projected to grow 50 percent between 2000 and 2040. The number of disabled adults ages 25 to 64 is also projected to grow during this period.[41]

Oregon's Long-Term System and Supports (LTSS) System Performance

Nursing Home Utilization

Oregon's nursing home bed supply has declined fairly steadily since 1998. In 2010, Oregon had only 24 beds per 1,000 persons 65 years of age and older compared to the national average of 42.[42]

Figure 6: Oregon's Nursing Home Bed Supply 1998-2010

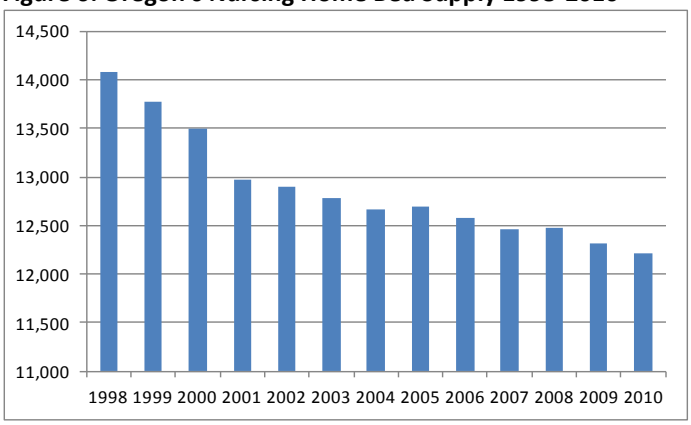
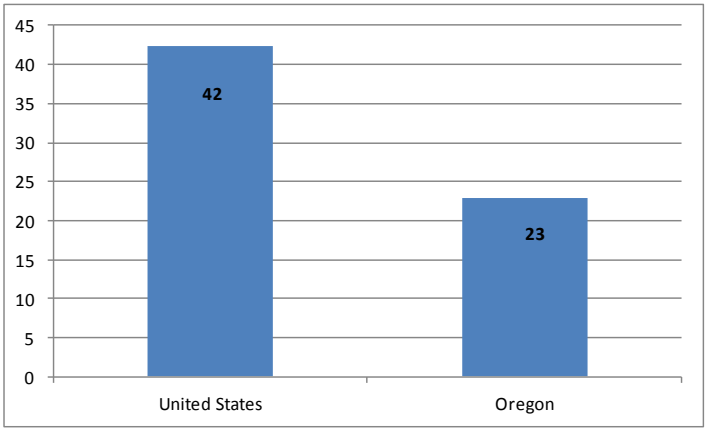


Figure 7: Nursing Home Beds per 1,000 Residents 65 years+, Oregon and US, 2010



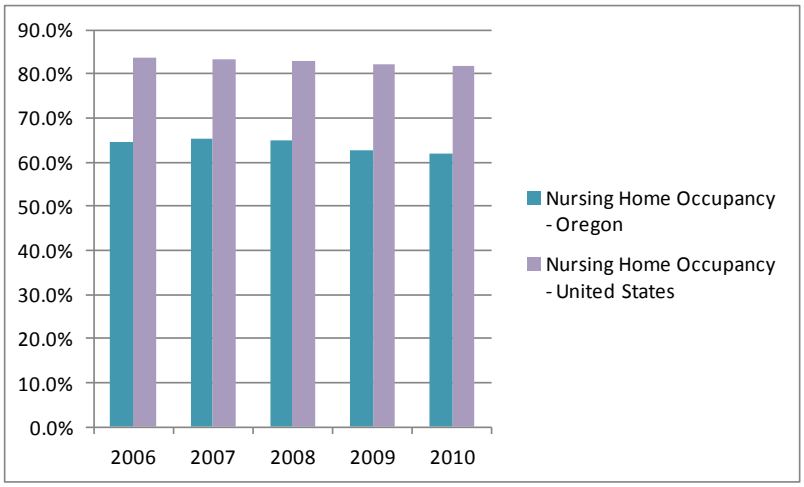
Sources: Figures 6 and 7 - CDC National Center for Health Statistics. Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995-2010. 2010 update. *Table 117. Office of Economic Analysis, Department of Administrative Services, State of Oregon.*

[41] Johnson, Richard W., Desmond Toohey, and Joshua M. Wiener. "Meeting the Long-Term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions." *The Retirement Project, Discussion Paper Series.* The Urban Institute, May 2007. Web. 18 Nov. 2011.

[42] Different data sources produce slightly different results. HMA calculations using 2010 US Census Data reveal 22.9 nursing home beds per 1,000 persons 65+ in Oregon. See Table 28.

Oregon has the lowest nursing facility occupancy rate in the nation at 61.8 percent, and occupancy declined from 2008, when it was 65 percent.[43] The national average occupancy rate in 2010 was 82 percent. (See Figure 8.)

Figure 8: Nursing Home Occupancy, Oregon and US, 2006-2010



Source: CDC National Center for Health Statistics. Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995-2010. 2010 update. *Table 117.*

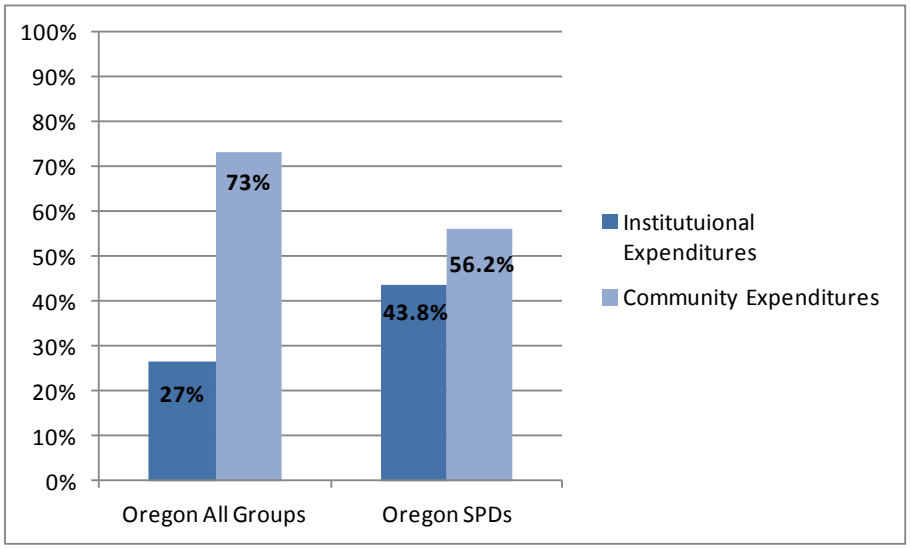
Medicaid Long-Term Care Spending

In 2009, Oregon ranked first across 39 states[44] for the percentage of Medicaid long-term care spending on home and community-based services (HCBS[45]) for all groups and third for Seniors and People with Disabilities. Oregon ranked fourth across 50 states for the percent of Medicaid *and* state- funded LTSS spending on HCBS for the aged and disabled.[46]

Overall, 73 percent of Medicaid long-term care dollars funded community-based care, while 56 percent of spending funded community-based care for Seniors and People with Disabilities. (See Figure 9 in this section and Figure A-1 and Tables A-1 and A-2 in the Appendices.)

[43] "Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995-2010. 2010 Update." Table 117. CDC National Center for Health Statistics. Web. 1 Dec. 2011.
[44] Eiken, Steve, Kate Sredl, Brian Burwell, and Lisa Gold. "Medicaid Long Term Care Expenditures in FY 2009." Thomson Reuters, 17 Aug. 2010. Web. 1 Dec. 2011. States with expenditures that could not be verified were excluded from the comparison.
[45] HCBS include personal care, home health, PACE, and HCBS targeting older adults and people with physical disabilities authorized under Sections 1115, 1915(c), 1915(j), and 1929.
[46] Reinhard, Susan C., Enid Kassner, Ari Houser, and Robert Mollica. "Raising Expectations - A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." AARP, The Commonwealth Fund, and The Scan Foundation. Sept. 2011. Web. 1 Dec. 2011.

Figure 9: Oregon Medicaid Long-Term Care Spending Distribution by Setting, FY 2009



Source: Eiken S, Sredl K, Burwell B, and Gold L. Medicaid Long Term Care Expenditures in FY 2009. *Thomson Reuters, August 2010.*

In 2009, Oregon was second among all 49 states for the number of assisted living and residential care units per 1,000 Oregonians age 65 years and older, having 64 beds per 1,000 residents. (See Figure A-3 and Table A-5 in the appendices for state and national data.) Oregon's supply is more than twice the national average of 31 beds per 1,000 residents. Minnesota, ranked number one, having 80 beds per 1,000 Minnesotans age 65 years and older.[47] As of June 30, 2011, Oregon had 11,985 ALF beds and 9,371 RCF beds.

Table 12: Oregon June 30, 2011 ALF and RCF Beds and Occupancy

Category	Number of Licensed Beds	Number of Occupied Beds	Occupancy Rate	Number of Medicaid Residents	Percent Medicaid
ALF	11,985	10,654	90%	4,206	40%
RCF	9,371	7,570	81%	2,831	37%

Source: Oregon DHS. *Home and Community Based Capacity Report*. June 30, 2011.

Oregon makes extensive use of Adult Foster Care Homes and has about 10,201 licensed AFCHs statewide. Nationwide, there were an estimated 18,900 adult foster homes in 2009 with a bed capacity of over 64,000.[48] There is no readily accessible data available on AFCH supply by state.

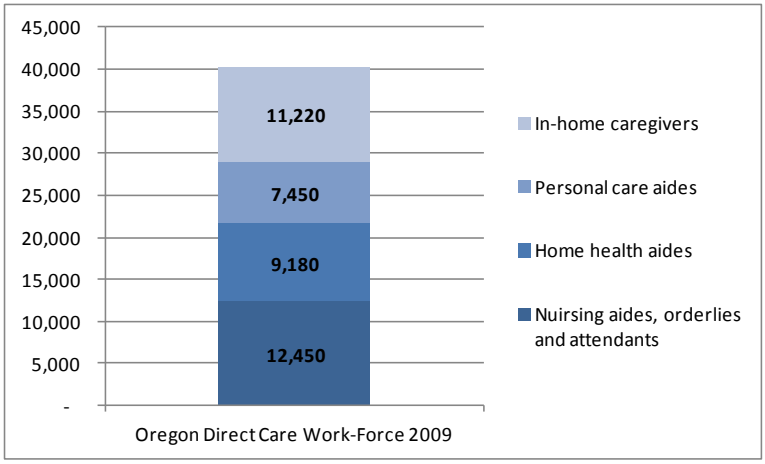
[47] Reinhard, Susan C., Enid Kassner, Ari Houser, and Robert Mollica. "Raising Expectations - A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." Exhibit A-7. AARP, The Commonwealth Fund, and The Scan Foundation. Sept. 2011. Web. 1 Dec. 2011.

[48] Mollica, Robert, Kristin Simms-Kastelein, Michael Cheek, Candace Baldwin, and Jennifer Farnham. "Building Adult Foster Care: What States Can Do." AARP Public Policy Institute. Sept. 2009. Web. 1 Dec. 2011.

Home Care Worker Supply

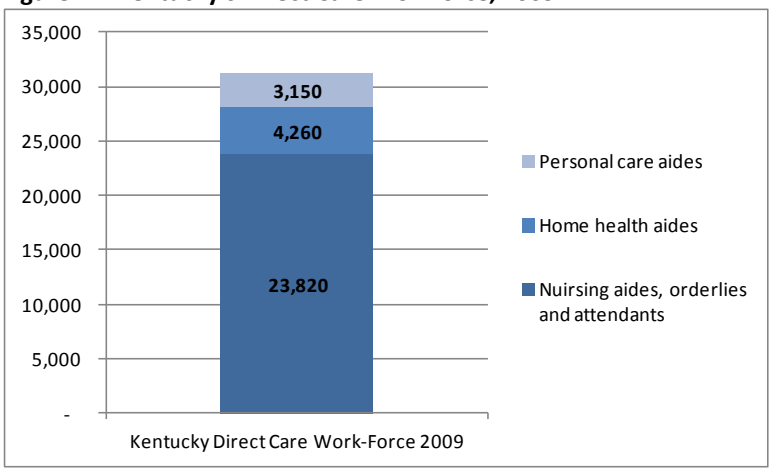
Oregon was ranked 29th of 48 states for the number of home health and personal care aides per 1,000 population age 65 years and older in 2009, with 32 per 1,000 compared to the national average of 40 per 1,000. Minnesota ranked first in this category with 108 per thousand, and Kentucky was last with 13 per 1,000.[49] (See Figure A-4 and Table A-6 in the Appendices for state and national rankings.) Oregon's distribution of direct care workers, as would be expected, reflects greater utilization of HCBS than institutional settings. (See Figure 10.)

Figure 10: Oregon's Direct Care Workforce, 2009



States, like Kentucky, that continue to spend the majority of their Medicaid long-term care funds on institutional care have a very different distribution. (See Figure 11.)

Figure 11: Kentucky's Direct Care Workforce, 2009



Source: Figures 9 and 10. PHI. National Clearinghouse on the Direct Care Workforce. The PHI State Data Center. http://phinational.org/policy/states/

[49] Reinhard, Susan C., Enid Kassner, Ari Houser, and Robert Mollica. "Raising Expectations - A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." AARP, The Commonwealth Fund, and The Scan Foundation. Sept. 2011. Web. 1 Dec. 2011.

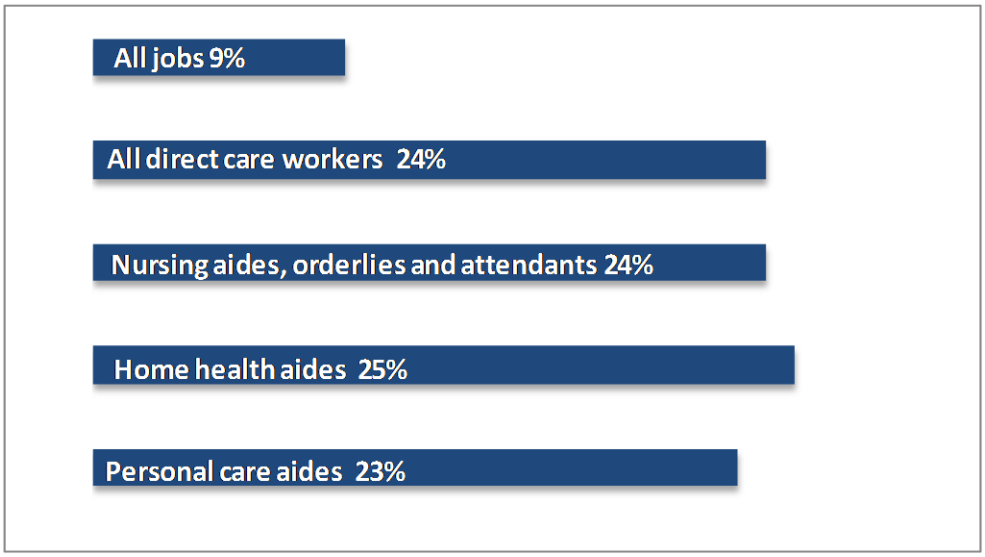
Nationally, home health aides and personal and home care aides are among the top 10 fastest growing occupations, with a projected growth rate of 50 percent and 46 percent, respectively, between 2008 and 2018. (See Table 14.)

Table 13: United States Growth in Demand for Direct Care Workers Compared to Other Occupations, 2008 to 2018

Rank	Occupation	Growth Rate
1	Biomedical Engineers	72.0%
2	Network systems and data communication analysts	53.4%
3	Home health aides	50.0%
4	Personal and home care aides	46.0%
5	Financial examiners	41.2%
6	Medical scientists, except epidemiologists	40.4%
7	Physician assistants	39.0%
8	Skin care specialists	37.9%
9	Biochemists and biophysicists	37.4%
10	Athletic trainers	37.0%

Oregon's projected demand is expected to be about half that of the national demand (See Figure 12), likely because Oregon already has already expanded HCBS and so has less potential demand compared to states with greater institutional use.

Figure 12: Oregon's Projected Need for Home Care Workers, 2008 to 2018

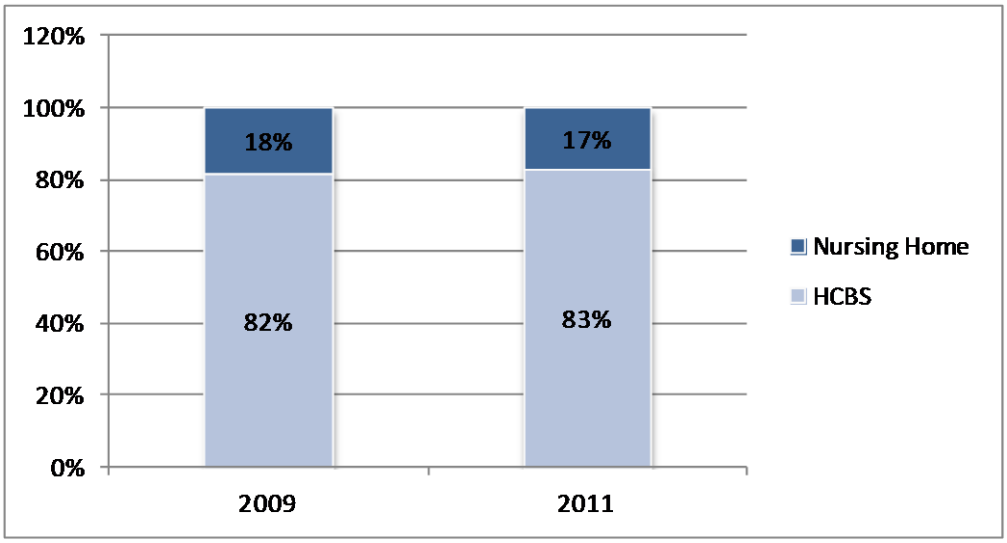


Source: Figure 11 and 12. PHI. National Clearinghouse on the Direct Care Workforce. The PHI State Data Center. Also, "Growing Demand for Direct Care Workers" page. http://phinational.org/policy/states/

Oregon's Long-Term Care System for Seniors and People with Physical Disabilities

Oregon's Medicaid-funded long-term care system consists of in-home care and institutional care. The majority of Oregon Seniors and People with Disabilities served by the SPD Division who are aged or who have physical disabilities (referred to as aged and physically disabled) receive long-term care as home and community-based services (HCBS).

Figure 13: Distribution of Medicaid-Funded Nursing Home and In-Home Care Recipients, October 2009 and October 2011



Sources: *DHS June 2009 Client Data Book and October 2011 Monthly Forecast Update.* DHS: SPD. Aged and Physically Disabled – June 2011 Actual Caseload.

The caseload of SPD Division aged and physically disabled recipients receiving Medicaid-funded LTC grew between 2009 and 2011, with Medicaid-funded nursing home utilization declining slightly. (See Table 15.) Note that this caseload data represents two points in time, not the annual caseload. Oregon's HCBS system is mature with no waiting list for the APD Waiver, which operates as an entitlement. Growth in the waiver is most likely primarily resulting from the growth of the population 65 years and older, although other factors such as increasing disability among non-elderly Americans and the increase in poverty might also be impacting enrollment.

Table 14: SPD Division Medicaid Caseload: HCBS and Nursing Home, June 2009 and June 2011

Medicaid-Funded SPD LTC Caseload	June 2009 Caseload	June 2011 Caseload	Change June 2009 Caseload to June 2011 Caseload
HCBS Caseload	21,382	23,256	+ 1,874
Nursing Home Caseload	4,817	4,761	-56
Total Caseload	26,199	28,017	+ 1,818

Sources: DHS June 2009 Client Data Book and October 2011 Monthly Forecast Update. DHS: SPD. Aged and Physically Disabled – June 2011 Actual Caseload.

Oregon utilizes a uniform assessment tool, the Client Assessment and Planning System (CA/PS), to prioritize access to nursing home and in-home care, with the exception of state plan personal care. Service priority levels are determined through use of a comprehensive assessment, conducted by a SPD/AAA case manager. This assessment documents a person's capabilities in the areas of activities of daily living (ADL) and instrumental activities of daily living (IADL). It also collects information about living environments, personal characteristics and preferences, treatments, and general health history.

Using a programmed algorithm, the CA/PS then calculates an individual's priority for receiving services based upon the degree of assistance an applicant requires with specific ADLs. This assessment tool is used to determine eligibility for home and community-based care as well as nursing facility care.

Table 15: Service Priority Level (SPL) Requirements for SPD Division Aged and Physically Disabled Clients

SPL	Requires:
Level 1	Full assistance in all major ADLs
Level 2	Full assistance in mobility, eating and cognition. Do not need help with elimination
Level 3	Full assistance in at least one; mobility, cognition or eating
Level 4	Full assistance in elimination
Level 5	Substantial assistance with mobility and eating and requires assistance with elimination
Level 6	Substantial assistance with mobility and eating
Level 7	Substantial assistance with mobility and assistance with elimination
Level 8	Assistance with mobility and eating and elimination.
Level 9	Assistance with eating and elimination
Level 10	Assistance with mobility
Level 11	Assistance with elimination and minimal assistance with ambulation
Level 12	Assistance with eating and minimal assistance with ambulation
Level 13	Assistance with elimination
Below this level not eligible for Medicaid-funded long-term care services. See OAR 411-015	
Level 14	Assistance with eating
Level 15	Minimal assistance with ambulation
Level 16	Full assistance with bathing or dressing
Level 17	Assistance with bathing or dressing
Level 18	Independent with above ADLs, but requires structured living for supervision for complex medical problems or a complex medication regimen

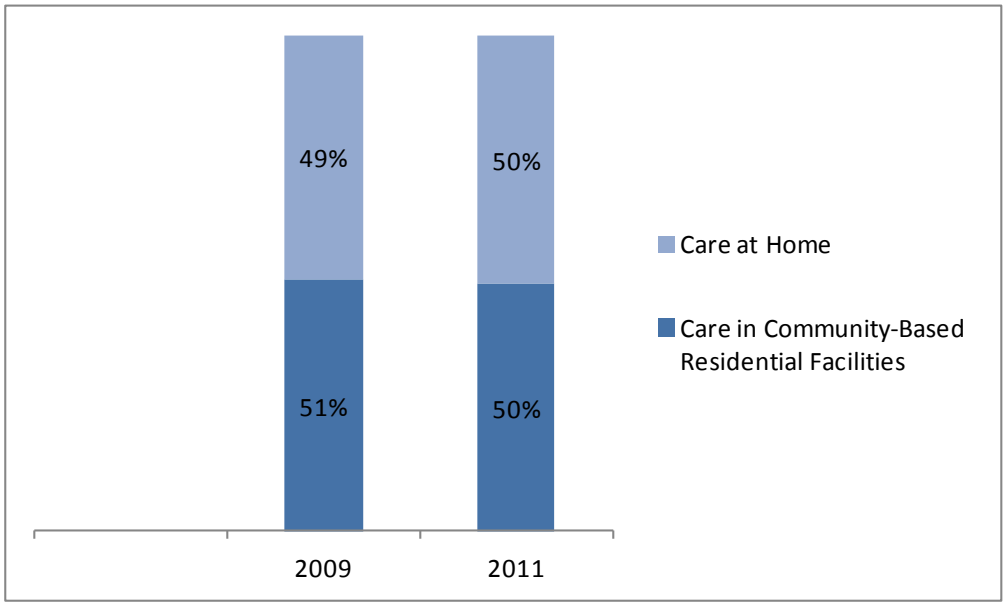
Medicaid-Funded In-Home Care

Oregon's Medicaid-funded in-home care for aged and physically disabled clients is funded primarily through the APD Waiver, with a more limited amount of in-home care provided through the Medicaid State Plan personal care program,[50] the Independent Choices program,[51] the Spousal Pay program and PACE program.

[50] Information on state plan personal care obtained from the Oregon Medicaid State Plan and from OAR 411-034.
[51] Not to be confused with Project Independence, a state-funded program for SPDs assessed as meeting the requirements of SPLs 1-18, subject to availability of funding.

In Oregon, about an equal number of SPD Division aged and physically disabled clients receiving in-home care receive this care in their own home or in a community-based residential facility.

Figure 14: Comparison of In-Home Care to Residential Care Caseload, June 2009 and June 2011



Sources: DHS June 2009 Client Data Book and October 2011 Monthly Forecast Update. DHS: SPD. Aged and Physically Disabled – June 2011 Actual Caseload.

Table 16: In-Home Care by Setting or Type of Care (June 2009 and 2011)

In-Home Services	June 2009 SPDs	June 2011 SPDs	Percent SPDs by Setting or Program June 2011
Non-Relative Foster Home	2,632	3,100	13%
Relative Foster Home[52]	1,567	1,537	7%
Assisted Living	3,868	4,130	18%
Residential Care Facility	955	1,000	4%
Contract Residential Care Facility	1,332	1,705	7%
Specialized Living	169	146	1%
All Residential Settings	**10,523**	**11,618**	**50%**
In-Home Hourly	8,732	9,534	41%
In-Home Live In	1,043	1,057	5%
Spousal Pay	135	137	1%
PACE	744	910	4%
Independent Choices	205	NA*	NA
All At-Home Care	**10,859**	**11,638**	**50%**
Total In-Home Services	**21,382**	**23,256**	**100%**

*Category not included in October 2011 Monthly Forecast Update. Sources: *DHS June 2009 Client Data Book and October 2011 Monthly Forecast Update*. DHS: SPD. Aged and Physically Disabled – June 2011 Actual Caseload.

[52] Adult Relative Foster Homes are required to be licensed, which includes completion of background checks, and services may not be provided by a resident's spouse. For these reasons, Adult Relative Foster Homes are included as residential settings rather than as a person's home.

In-home care delivered at-home in Oregon is provided using two models of delivery: the Client Employed Provider Program (CEP) and through services contracted through in-home care agencies.

The Client Employed Provider Program (CEP) is a consumer-directed care program. The client, who can be assisted by a case manager, is the in-home worker's employer. Client responsibilities include:

- locating, screening, and hiring workers;
- supervising and training employees;
- scheduling workers and finding coverage when they are on leave;
- tracking the hours they work;
- addressing any performance issues; and
- discharging workers when their performance has been unsatisfactory.

All full-time, part-time, hourly, and live-in publicly funded homecare workers who are Client-Employed Providers (CEPs), Spousal Pay Providers, State Plan personal care providers and providers in the Oregon Project Independence (OPI) Program are part of single bargaining unit of the Service Employees International Union (Local 503).

Contracted in-home care agencies are licensed by the Oregon Health Care Authority to provide in-home care services.[53] The agencies:

- schedule caregivers;
- assign work;
- assign compensation rates;
- define working conditions;
- negotiate for a caregiver or client for the provision of services; or
- place a caregiver with a client.

Homecare workers and In-Home Agencies must have an active Medicaid provider number in order to provide in-home care. Homecare workers employed by agencies are excluded from the SEIU agreement.

In-Home Care and Medicaid Funding

In-home care is funded primarily through the APD Waiver for SPD Division aged and physically disabled clients. Medicaid-funded in-home care is also provided through the Independent Choices program. Similar to the CEP, Independent Choices is a consumer-directed program but provides clients with cash payments (funded by Medicaid) to purchase in-home services. About 300 SPD Division aged and physically disabled clients receive cash payments through the Independent Choices Program.[54]

In-home care includes care provided by spouses both through Independent Choices and through the APD Waiver under specific circumstances (e.g., when the client needs extraordinary care). Spouses must

[53] OAR chapter 333, division 536.
[54] "Spring 2011 DHS and OHA Caseload Forecast." Budget, Planning and Analysis; Office of Forecasting, Research and Analysis; Oregon Department of Human Services. May 2011. 49. Web. 1 Dec. 2011.

provide services that exceed what would usually be expected of a husband or wife. In September 2011, 138 SPD Division aged and physically disabled clients were receiving in-home care from spouses (just under 1 percent of all SPD Division aged and physically disabled in-home hourly care users and just 0.5 percent of all SPD LTC users).

Table 17: Spousal Pay Caseload, September 2011

September 2011 SPD Division Aged and Physically Disabled Client Caseload	Count
All Long-Term Care (LTC)	28,222
In-Home Hourly Care	9,558
Spousal Pay	138
Spousal Pay as a % of All LTC	0.5%
Spousal Pay as a % of All In-Home Hourly Care	1%

Source: Forecasting, Research and Analysis. Monthly Forecast Update. Department of Human Services: Seniors and People with Disabilities, Aged and Physically Disabled. October 2011.

State plan personal care is another way that in-home care may be funded. However, HCBS waiver enrollees, PACE enrollees, and anyone living in a licensed residential setting may not receive state plan personal care. In September 2011, 943 SPD clients received state plan personal care.

In FY 2011, about 15,000 SPD Division aged and physically disabled clients received in-home care through the waiver or through these other programs.

Program of All-Inclusive Care for the Elderly (PACE)

States may operate Programs of All-Inclusive Care for the Elderly (PACE), which are authorized under the Medicaid state plan. Twenty-nine states had operational PACE programs in January 2011 with total enrollment of 21,751 persons.[55]

The PACE provides services to persons who are at least 55 years old, who live in the PACE service area, and who meet nursing home level of care. The PACE program provides for all of the participant's care needs, including Medicare and Medicaid service needs. An interdisciplinary team assesses the participants' needs, develops care plans, and delivers all services (including acute care services and, when necessary, nursing facility services). Services are provided primarily in an adult day health center and may be supplemented by in-home and referral services when needed.

PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount the PACE provider receives from the state.

Oregon PACE providers must provide the following long-term care services:

- In-Home Services
- Home delivered meals
- Personal care services

[55] "List of PACE Programs by State." National PACE Association. Web. 7 Nov. 2011.

- Adult day services
- Residential Care Facility services
- Assisted Living Facility services
- Adult Foster Home services
- Nursing Facility services

Oregon currently has one PACE provider—Providence ElderPlace in Portland, Oregon. In September 2011, ElderPlace had 923 enrollees (just 3 percent of the LTC caseload).

Table 18: SPD PACE Caseload

September 2011 SPD Division Aged and Physically Disabled Client Caseload	Count
All Long-Term Care	28,222
PACE	923
PACE as a % of All LTC	3%

Source: Forecasting, Research and Analysis. Monthly Forecast Update. Department of Human Services: Seniors and People with Disabilities, Aged and Physically Disabled. October 2011.

APD Waiver

Oregon operates one home and community-based services (HCBS) waiver for SPD Division aged and physically disabled clients, the Aged and Physically Disabled (APD) Waiver.

Many states, such as Oregon, provide Medicaid-funded in-home care primarily through HCBS waivers. In 2009, Oregon spent over $28 million on personal care services but over $369 million for APD Waiver services and over $519 million for DD Waiver services.

Table 19: Selected Oregon Home and Community-Based Services Expenditures, FY 2009

Oregon Service Type	FY 2009 Expenditures
Personal Care	$28,074,338
Home Health	$973,283
PACE	$26,160,809
HCBS - 1915(j) (Independent Choices)	$14,198,583
1915(c) Waivers: APD	$369,698,324
1915(c) Waivers: DD	$519,183,712

Source: Eiken, Steve; Sredl, Kate; Burwell, Brian; Gold, Lisa. Medicaid Expenditures for Long-Term Services and Supports: 2011 Update. E-mail distribution from Steve Eiken, 11/08/2011.

States often choose to provide in-home and other community-based care through HCBS waivers rather than under state plan options, such as personal care and the newer HCBS state plan option (Section 1915(i) of the Social Security Act,) because HCBS waivers provide states with additional flexibility in managing costs.

- States may cap enrollment in a HCBS waiver up to a number specified by the state. State plan personal care and HCBS are entitlements and may not be made unavailable once a certain number of Medicaid recipients are enrolled or the state has expended a certain amount of money.

- States may specify a maximum annual cost of care that serves as a limit for access to the waiver. The limit can be an amount less than, equal to, or greater than the cost of institutional care. This type of limit may not be used to restrict access to state plan personal care and HCBS.

Other limitations, such as limits on the amount, duration and/or scope of services may be applied in both waivers and under the state plan, but there is a risk that reducing in-home services will result in increased costs in other areas, such as for residential care, including nursing home care.

Other reductions, such as rate cuts and changes to methods for determination of waiver eligibility can also be implemented but can likewise result in increased expenditures in other services. In addition, the options are limited by federal maintenance of effort (MOE) provisions in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (together known as the Affordable Care Act).[56]

If a state attempts to make modifications that have the effect of constricting waiver eligibility prior to the waiver renewal period, the state would be in violation of MOE requirements. It is not entirely clear what specific actions would be included as having the effect of constricting eligibility. For example, placing a cap on the waiver does not change the eligibility requirements for the waiver but does reduce access. In addition, waivers can be modified during the waiver renewal period in a manner that reduces eligibility as long as the state and CMS agree to a plan that describes steps to ensure minimal adverse impact on individuals served. If states propose to modify eligibility before the waiver renewal period, CMS may find the state to be in violation of MOE requirements.[57]

It is likely that CMS will consider the imposition of a cap on enrollment or an institutional cost limit as restricting Medicaid eligibility. Therefore, this change could only be implemented:

- During waiver renewal (not until 2017).
- When Medicaid Maintenance of Effort (MOE) requirements for adults end in 2014.
- If the state terminates the waiver and subsequently develops a new waiver (and CMS could still determine that this action violated MOE requirements.)

The MOE provisions do not affect a state's ability to manage waiver costs by modifying waiver benefits or rates or introducing new waiver service-specific medical necessity criteria or utilization controls as long as these do not affect individuals' eligibility for Medicaid. For example, the state could reduce the number of in-home hours available to enrollees, or require that enrollees have a greater level of functional impairment than was required previously to access a specific service.

[56] For more information see the State Medicaid Director letter SMDL#11-009, ACA# 19 at: https://www.cms.gov/smdl/downloads/SMD11-009.pdf

[57] "State Medicaid Directors Letter # 11-009, ACA#19." Centers for Medicare and Medicaid Services (CMS), 5 Aug. 2011. Web. 1 Dec. 2011.

HCBS Waivers and Eligibility

HCBS waivers may be used to serve persons who would otherwise require care in a nursing home, intermediate care facility for persons with developmental disabilities (ICF/DD) or hospital, the cost of which is reimbursable under the Medicaid state plan. States must specify which of these levels of care are included in each waiver.

Under current HCBS waiver regulations, a waiver may serve one of the three target groups: aged or disabled, or both; mentally retarded or developmentally disabled, or both; and mentally ill. A HCBS waiver may not serve two target groups within a single waiver (although a pending rule may result in a change to this limitation).[58] A waiver may, however, include more than one level of care. For example, a HCBS waiver serving the aged and disabled could include persons in this target group who would otherwise require nursing home *or* hospital level of care. Because of the wording of the existing rule, a HCBS waiver targeting children or adults with mental illness is required to be separate from other HCBS waivers. (However, persons who have a mental illness who need nursing home level of care might be served in a nursing home level of care waiver if they meet all of that waiver's eligibility requirements.)

States may serve adults and children of all ages in a waiver or may limit the age groups included.

States may set additional eligibility requirements based on factors such as frailty, diagnosis, or living arrangement. For example, a number of states operate HCBS waivers for persons who have an HIV/AIDS diagnosis or traumatic brain injury diagnosis.

States may also determine which existing eligibility groups are included in the waiver and may allow higher-income persons to participate and therefore become Medicaid eligible (in the same manner as is made available to nursing home applicants). The higher-income group, also known as the special home and community-based services waiver eligibility group, consists of applicants who require HCBS waiver services and who have income up to 300 percent of the maximum supplemental security income (SSI) benefit (or about 223 percent of Federal Poverty level) or another level specified by the state. Inclusion of persons at higher incomes permits these persons to access all Medicaid state plan services for which they qualify and the HCBS waiver services upon enrollment into the HCBS waiver.

States may limit eligibility for waiver services to applicants whose expected cost of care for waiver services plus state plan services during the waiver year exceeds an amount specified by the state. The cost limit may be set at:

- A cost limit in excess of institutional costs
- An institutional cost limit
- A cost limit lower than institutional costs

In 2009, 36 states imposed some type of cost limit in one or more of their HCBS waivers (including Oregon) and twenty states set service limits.

There are reportedly eleven states without waiting lists for one or more of their HCBS waivers in 2010.

[58] "Proposed Rule: Medicaid Program; Home and Community-Based Services (HCBS) Waivers." *Federal Register* 76.73. 15 Apr. 2011. Web. 1 Dec. 2011.

In 2009, 36 states imposed some type of cost limit in one or more of their HCBS waivers (including Oregon) and 20 states set service limits.[59] There is no readily available information that specifies how many states limit HCBS waiver enrollment to persons whose cost of care is projected to be less than the institutional cost.

Some states operate their HCBS waiver programs as "entitlements," including Oregon, Washington and Alaska. A few states operate specific (rather than all) HCBS waivers as entitlements, including California and Michigan, where HCBS waivers for persons with IDD are entitlements. There are reportedly 11 states (including the five states cited previously) without waiting lists for one or more of their HCBS waivers in 2010.[60]

APD Waiver Eligibility

In order to be eligible for the APD Waiver, a person must be:

- Aged or disabled
- 18 years of age or older
- Be determined to meet nursing home level of care
- Be in one of the Medicaid eligibility groups included in the waiver

Oregon includes the following eligibility groups in the APD waiver:

- SSI recipients
- Optional State supplement recipients
- Working individuals with disabilities who buy into Medicaid (Employed Person with Disabilities)
- The special HCBS waiver group for persons with income up to 300 percent of SSI. (Oregon is one of 39 states electing this option in an HCBS waiver.)

Oregon offers the same spousal impoverishment protections to HCBS waiver recipients as it does to nursing home recipients. Only five states do not. Oregon does not have a medically needy program; 35 states do. States with a medically needy program may include this group in a HCBS waiver at their option.

Oregon does not set a cost limit as a condition of enrollment into the waiver. (This cost limit is different from the cost limit that may be set on a care plan or set of services, as explained later in this section.)

HCBS Waiver Covered Services

States specify the services that are included in the HCBS waiver, which must be approved by the federal Centers for Medicare and Medicaid Services (CMS). These services include case management services,

[59] "Medicaid Home and Community-Based Service Programs: Data Update." *Issue Paper*. Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, Feb. 2011. Web. 1 Dec. 2011.
[60] Doty, Pamela. "Testimony for the California Little Hoover Commission." Hearing in Sacramento, CA on California's System of Long-Term Care. 27 May 2010. Web. 12 Dec. 2011.

homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and other services requested by the state and approved by CMS. A state may also include, for persons with chronic mental illness, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services.

Services must be clearly defined and must not duplicate state plan services, (although a service may provide for an additional amount of a state plan service, such as additional hours of personal care, in which case the service is considered to be an "extended state plan service").

HCBS waiver services (with the exception of extended state plan services) must be necessary to avoid institutionalization and address functional impairments or other participant needs that, if left unaddressed, would prevent the person from engaging in everyday community activities. States must assure the health and welfare of persons enrolled in a HCBS waiver. Therefore, any limits on the amount, duration, and frequency of the services must be consistent with this assurance.[61]

APD Waiver Covered Services

Oregon covers an array of services through the waiver and requires that at least one waiver service be received monthly for continued enrollment. Covered services are:

- Adult Day Services
- Home Accessibility Adaptations
- Non-Medical Service Transportation
- Non-Relative Adult Foster Care
- Relative Adult Foster Care
- Residential Care Facilities [services]
- Assisted Living Facilities [services]
- Home- Delivered Meals
- Specialized Living Services
- In-Home Services
- Community Transition Services

HCBS Waiver Limits on Services

States may impose limits on services in addition to customary requirements related to medical necessity. These limits are:

- *A limit on a set of services*: a maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

[61] "Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]. Instructions, Technical Guide and Review Criteria." Centers for Medicare and Medicaid Services (CMS), Jan. 2008.

- A *Prospective Individual Budget Amount*, which is a maximum dollar amount of waiver services authorized for each specific participant.
- *Budget Limits by Level of Support*. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
- *Another type of limit specified by the state.*

APD Waiver Service Limits

The SPD Division has elected to set limits based on the total continuing cost of waiver services for an individual in a community-based setting, which may not exceed the comparable nursing facility rate. Therefore, a person whose initial cost of care was expected to be greater than the cost of nursing home care can be enrolled into the APD Waiver as long as the cost over time is reduced to no greater than nursing home cost. This option allows the state to avoid admitting persons to nursing homes solely because they require higher-cost care following an initial period of illness, catastrophic injury, or hospitalization.

The SPD Division may grant exceptions to the nursing facility cost limit when:

- there is a specific rehabilitation plan approved by the SPD Division, with goals and a definite time frame for delivery, that will improve the individual's self-sufficiency; or
- the SPD Division determines that intensive convalescent care is required for a limited period of time; or
- the SPD Division determines that intensive long-term care or special technology is required, but is otherwise available locally only in an acute care facility (hospital); and
- the SPD Division has reviewed the costs of service to be provided and determined that these are reasonable.

The participant's CA/PS assessment determines the amount and scope of services required by the individual. For in-home services, the assessment suggests an amount of paid hours within each ADL and IADL category. The case manager then authorizes hours up to the maximum allowed by administrative rule. For residential care, reimbursement rates for facilities are based on assessed need. Participants with more complex needs will be approved for a higher residential reimbursement rate. Other services are authorized based on assessed need. Rates may be provider-specific (for adult day services) or set on a statewide basis (for home-delivered meals).

Only the services identified in the plan of care may be reimbursed.

Once enrolled, if the continuing cost of care is expected to remain higher, or if it becomes higher than the nursing facility cost, the enrollee may be disenrolled unless approved for continued enrollment on the basis of the permitted exceptions.[62]

[62] Based on OAR 411-027 "Payment Limitations in Community-Based Care Services".

HCBS Waiver Budget Neutrality

The cost effectiveness of HCBS waivers is determined by comparing the cost of waiver services (D) plus the cost of other Medicaid services, such as physician and hospital service (D'), to the cost for institutional (in this case, nursing home) services (G) plus the cost for any other Medicaid services (G'). On average, D + D' must be equal to or less than G + G'.

The state must assure that the average per capita expenditure under the waiver during each waiver year does not exceed 100 percent of the average per capita expenditures that would have been made during the same year for the level of care provided in the waiver had the waiver not been granted. States that do not impose a cost limit in the waiver are able to meet this requirement when there are enough enrollees with a cost of care lower than the institutional cost to offset the cost of care for enrollees who are more expensive than the average institutional care cost.

The state must estimate and document the anticipated waiver services and state plan services cost for waiver enrollees, annualize this cost, and project the cost for each year of the waiver period. The state is required to demonstrate compliance with the budget neutrality requirement by completing an annual report (called a CMS-372 report).

APD Waiver Budget Neutrality

The APD Waiver met the budget neutrality requirements in FYs 2008 and 2009 using the waiver formula D + D' (Row 5 in Table 21 below) is equal to or less than G + G' (Row 8).

Table 20: APD Waiver Enrollees, Expenditures, and Budget Neutrality, FY 2008 and FY 2009

Row	Category	FY 2008	FY 2009
1	**Unduplicated waiver participants**	27,403	28,300
2	**Cost of waiver services**	$ 281,832,774	$ 349,035,602
3	**Average cost waiver services per participant (D)**	$ 10,285	$ 12,333
4	**Cost of other Medicaid services per participant (D')**	$ 4,374	$ 4,418
5	**Total average cost for waiver participants (D+D')**	$ 14,659	$ 16,751
6	**Cost for nursing home services (G)**	$ 27,072	$ 27,884
7	**Cost of other Medicaid services for nursing home residents (G')**	$ 2,139	$ 2,231
8	**Total average cost for nursing home residents (G+G')**	$ 29,211	$ 30,115
9	**Number of waiver days**	7,794,234	8,003,808
10	**Average length of stay in waiver (days)**	284	283

Note that the average cost for waiver participants does not reflect the cost for each participant or any specific participant. Some participants cost less and some more than the average cost displayed in Row 5.

Other Public HCBS

Older Americans Act

DHS is the single state agency for the Older Americans Act (OAA) program in Oregon. The SPD Division functions as the state Aging Unit and administers the services and funds available through OAA and contracts with Area Agencies on Aging (AAAs) for local administration and service provision. The SPD Division targets OAA services to persons 60 years of age or older who have greatest social or economic need, with a special focus on low-income minority individuals and individuals living in rural areas.

In 2010, more than 323,000 Oregonians received OAA services.[63] Services funded through the OAA include:

- Elder abuse prevention
- Family caregiver support
- Legal issues
- Medication management
- Nutrition services
- Senior employment
- Support services

Oregon Project Independence Programs

Oregon Project Independence (OPI) provides in-home services to individuals who are age 60 and older or individuals who have been diagnosed with Alzheimer's disease or a related disorder but who typically do not qualify for Medicaid due to income or assets. OPI is designed to reduce or delay the need for nursing home care. OPI funds may be used for the following services:

- Homemaker (Home Care) services
- Chore services
- Assisted transportation (Escort)
- Home health services
- Personal services
- Adult Day services
- Respite care
- Information and Assistance
- Registered nurse services
- Home delivered meals

About 2,000 SPD Division aged or physically disabled clients receive OPI services.[64]

[63] "Seniors and Persons with Disabilities (SPD) Overview." Department of Health Services 9384. Revision Sept. 2010.

Oregon Nursing Home Care

There were 137 nursing homes in Oregon in 2010 with 12,202 certified beds and 7,506 residents for an average occupancy rate of 62 percent, the lowest nursing home occupancy rate in the nation. Oregon nursing home occupancy has trended downward steadily since 1995 and at a rate far faster than the national average between 1995 and 2009.[65]

Figure 15: Number and Percentage of Oregon Nursing Home Beds Occupied/Empty, 2010

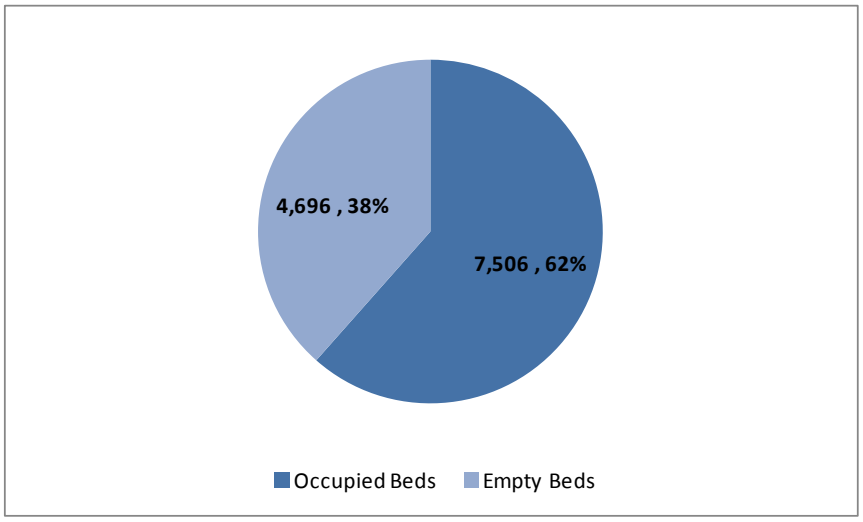
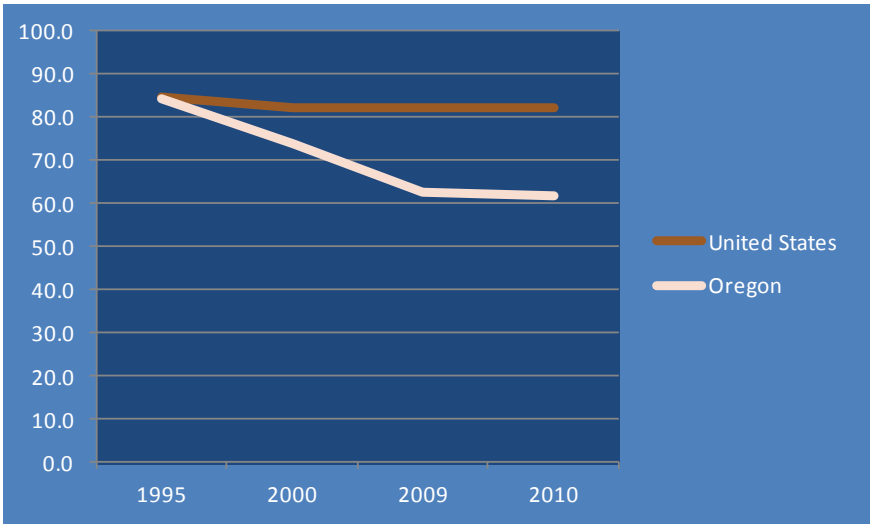


Figure 16: United States and Oregon Nursing Home Occupancy, 1995 to 2010



[64]Toews, James. "Seniors and Persons with Disabilities (SPD) Division." *PowerPoint Presentation*. 8 Feb. 2011.
[65] All CMS nursing home data from the CMS Nursing Home Compare Nursing Home data unless otherwise noted. Retrieved October 27, 2011 from http://www.medicare.gov/Download.

(See tables A-7, A-8 and A-9 and Figure A-5 in the Appendices for average occupancy rates and beds per 1,000 population 65+ by state and for the United States for 1995, 2000, 2009 and 2010.)

Oregon's officially reported nursing home occupancy does not reflect the actual number of available beds. Bed counts include beds that are vacant as well as rooms that were previously double-occupancy and that are now private, and rooms that have been converted to other uses.

A 2008 Nursing Facility report that included survey responses from nursing homes found that available beds (i.e., ready to move into and staffed) were 88.1 percent of licensed capacity (meaning that 11.9 percent of beds were unavailable for use).

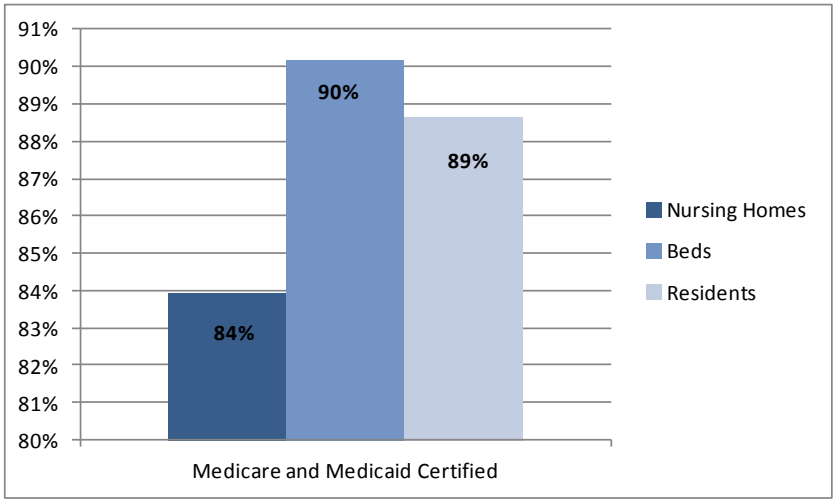
Data for 2009 revealed that across all nursing homes, occupancy rates were about 77.6 percent in Oregon, lower than the national average of 82 percent in 2010.[66]

Eighty-four percent of Oregon's nursing homes were Medicare and Medicaid certified in 2010 compared to the 2009 national average of 95 percent.

However, 90 percent of Oregon nursing home certified beds were dually certified, and 89 percent of nursing home residents were residing in these dually certified beds on average in 2010.

Nationally, Medicare-only and Medicaid-only nursing homes have been declining as a percentage of all nursing homes.[67]

Figure 17: Percent of Oregon Nursing Homes, Beds, and Residents by Certification Status, 2010

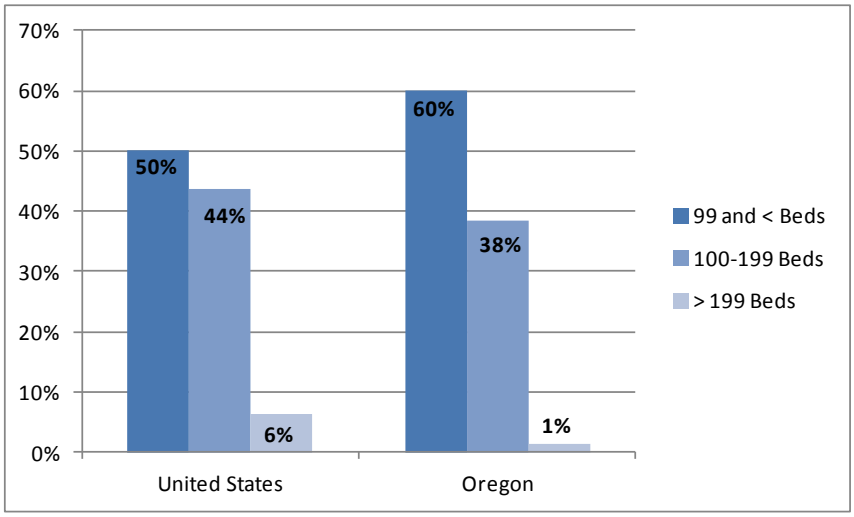


Source: Centers for Medicare and Medicaid Services (CMS) Nursing Home Compendium 2010.

[66] "Oregon Nursing Facilities: A report on the utilization of nursing facilities in the State of Oregon in 2008." Office for Oregon Health Policy and Research, Oct. 2009.

[67] "Nursing Home Data Compendium 2010 Edition." Centers for Medicare and Medicaid Services (CMS). Page i. 2010. Web. 1 Dec. 2011.

Figure 18: Percent of Oregon and US Nursing Homes by Bed Size, 2009

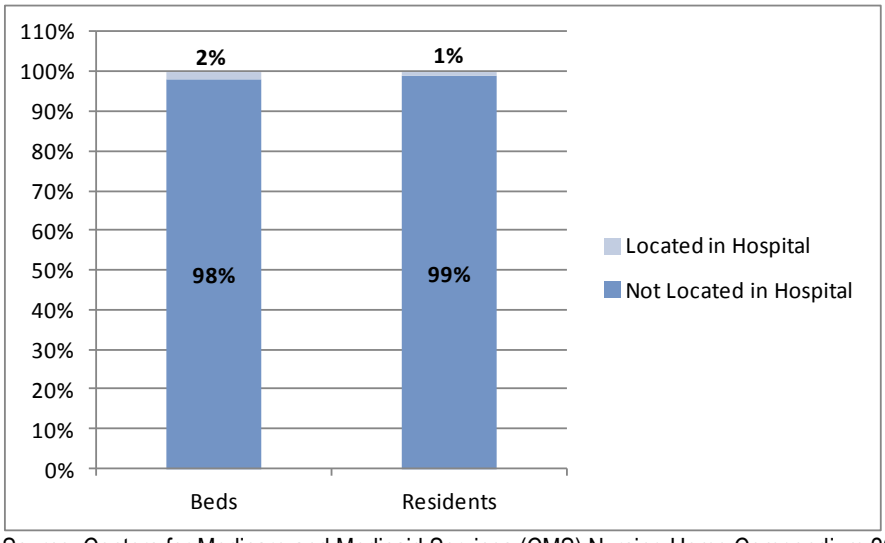


Source: Centers for Medicare and Medicaid Services (CMS) Nursing Home Compendium 2010.

In 2009, Oregon nursing homes were more likely to be smaller (99 beds or less) than nursing homes on average across the United States.

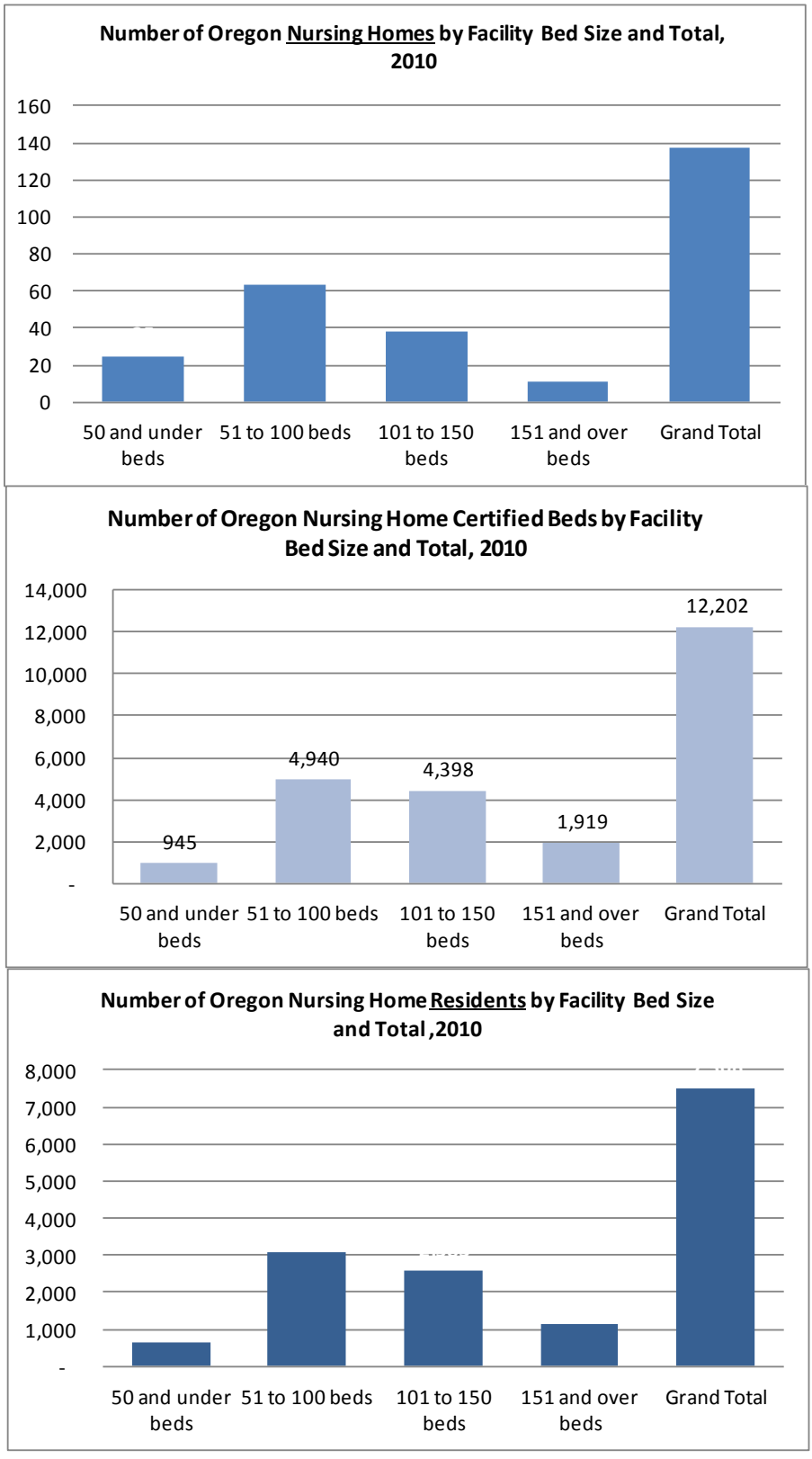
Hospital-based and CCRC nursing home beds (and the residents in these beds) represented a very small percentage of all nursing home beds and residents in 2010.

Figure 19: Percent of Oregon Nursing Home Beds and Residents by Nursing Home Type, 2010



Source: Centers for Medicare and Medicaid Services (CMS) Nursing Home Compendium 2010.

Figure 20: Oregon Nursing Homes and Residents by Facility Bed Size, 2010



Nursing Home Coverage

The cost of nursing home care is funded primarily by Medicare, Medicaid, and personal funds.

Medicare covers short-term stays following hospitalization and covers skilled nursing care and rehabilitation for up to 100 days at varying payment amounts.

Long-term nursing home care is funded by Medicaid, if a person is not Medicare-eligible or does not have a Medicare-qualifying stay, or once a person exhausts their Medicare or other coverage (after the 100th day) and does not have sufficient funds to cover the cost for this care (and meets other eligibility requirements). Medicaid also pays Medicare cost-sharing amounts for persons who are dually eligible for Medicaid and Medicare.

Medicaid Coverage

Oregon Medicaid covers nursing home care for persons who are assessed as having a Service Priority Level 1 through 13 (the same levels used for the APD Waiver) and who are financially eligible for Medicaid.

Medicaid-funded nursing home care is reimbursed using six major[68] classifications of care:

- NF - Pediatric
- NF - OHP Post Hospital Extended Care
- NF - Medicare Extended Care
- NF - Enhanced Care
- NF - Complex
- NF - Basic

In FY 2011, more than 60 percent of nursing home paid claims for SPD Division aged and physically disabled clients were for NF-basic services, another 20 percent for NF-complex services, and 15 percent for Medicare extended care.

The basic rate is authorized by the SPD Division for clients who require daily, intermittent licensed nurse observation and continuous nursing care. The complex rate is an add-on payment designed to cover the additional costs associated with meeting the needs of residents who require one or more special treatments, procedures, and services such as intravenous medication, tube feeding, or ventilator care.[69] Dual-eligible clients (eligible for both Medicare and Medicaid) who have been placed in a nursing home after a Medicare-qualifying hospital stay are classified as Medicare extended care for the purpose of reimbursement.

[68] For the purposes of billing, additional categories exist, including Medicare co-insurance billings.
[69] OAR 411-070.

Nursing Home Residents with Low-Care Needs

Nursing homes typically serve persons with higher care needs than the average person residing in the community. However, some nursing home residents have "low care needs." Low care needs residents do not require physical assistance in bed mobility, transferring, using the toilet, or eating and do not have complex medical care needs. A number of factors may result in the presence of low-care residents in nursing homes, including personal or family choice and lack of access to specific supports (such as housing or in-home providers, especially in rural areas).

Oregon was ranked 13th across 48 states in 2007 for the percent of nursing home residents with low care needs. (See Figure A-6 and Table A-10 in the Appendices for state and national rankings.) Oregon's percentage of 8.3 percent was lower than the national average of 12.8 percent but significantly higher than the state with the lowest percentage—Maine at 1.3 percent. Maine is a significant outlier. The next lowest state, Hawaii, has 6 percent of nursing home residents assessed as having low-care needs.

Many states, including Oregon, have targeted low care needs nursing home residents for transition out of facilities; they have met with varying levels of success. Once a person enters a nursing home and loses access to their housing and to caregivers, discharge back to the community is quite difficult.

Oregon requires that all potentially Medicaid-eligible individuals who are at risk for nursing facility services and all non-Medicaid-eligible individuals applying as new admissions to a Medicaid-certified nursing facility receive a preadmission screening (PAS). The PAS includes:

- Completion of the Client Assessment and Planning System (CA/PS).
- The determination of an individual's service eligibility for Medicaid-paid long-term care or post-hospital extended care services in a nursing facility.
- Determination of whether they can be diverted from nursing homes or transitioned to community-based service settings.
- The provision of information about community-based services and resources to meet the individual's needs.
- Transition planning assistance as needed.

In this manner, Oregon is able to divert people from nursing homes before they enter or to intervene early when a person transitions to Medicaid-paid nursing home care, increasing the likelihood that a person with long-term care needs will reside at home or in alternative community setting when feasible.

Oregon's Nursing Home Capacity into the Future

Oregon appears to have adequate nursing home capacity through 2020, based on the current number of licensed beds and existing utilization rate as the population aged 65+ grows. (See Table 22.)

Table 21: Oregon Nursing Home Beds and Residents if Utilization Remains Constant from 2010 through 2020

Category	Oregon 2010	Oregon 2015	Oregon 2020
Nursing Home Beds	12,218	12,218	12,218
Nursing Home Residents	7,549	9,108	11,035
Population Age 65+	501,944	605,606	733,756
Nursing Home Residents per 1,000 65+	15.04	15.04	15.04
Beds Over/(Under) Based on 2010 Bed Supply	4,669	3,110	1,183

If nursing home utilization remained flat despite the growth in the population age 65 years and older, Oregon's nursing home utilization rate (beds or residents per 1,000 population age 65 years and older) would decline. (See Table 23.)

Table 22: Oregon Nursing Home Beds and Residents if the Number of Residents Remains Constant from 2010 through 2020

Category	Oregon 2010	Oregon 2015	Oregon 2020
Nursing Home Beds	12,218	12,218	12,218
Population Age 65+	501,944	605,606	733,756
Nursing Home Beds per 1,000 65+	24.34	20.17	16.65
Nursing Home Residents (Constant Number)	7,549	7,549	7,549
Population Age 65+	501,944	605,606	733,756
Nursing Home Residents per 1,000 65+	15.04	12.47	10.29

Sources: 2010 Nursing home Beds and Residents: CDC National Center for Health Statistics. Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995-2010. 2010 update. Table 117. Population 65+: Office of Economic Analysis, Department of Administrative Services, State of Oregon; and U.S. Census Bureau, Population Division.

However, actual use could vary substantially depending on changes in disability rates, income, and public policy. For example, if access to HCBS were reduced, utilization would likely increase and, coupled with the projected growth in the 65+ population as well as some growth in the adult non-elderly population with disabilities, could eventually result in a nursing home bed need.

Appendices

Source Notes

- Nursing Home data is from the CDC National Center for Health Statistics: *Nursing homes, beds, residents, and occupancy rates, by state: United States* – except as otherwise noted.
- Data identified as from the State Scorecard on LTSS is from:

  Reinhard, Susan C., Kassner, Enid, Houser, Ari, and Mollica, Robert. *Raising Expectations - A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. AARP. September 2011.
- Conversion of tables to figures was done by HMA.

Table A-1: LTSS Scorecard Indicators

	Measure
1.	Median annual nursing home private pay cost as a percentage of median household income age 65+
2.	Median annual home care private pay cost as a percentage of median household income age 65+
3.	Private long-term care insurance policies in effect per 1,000 population age 40+
4.	Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance
5.	Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community
6.	ADRC/Single Entry Point functionality (composite indicator, scale 0–12)
7.	Choice of Setting and Provider
8.	Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities
9.	Percent of new Medicaid LTSS users first receiving services in the community
10.	Number of people consumer-directing services per 1,000 adults age 18+ with disabilities
11.	Home health and personal care aides per 1,000 population age 65+
12.	Assisted living and residential care units per 1,000 population age 65+
13.	Percent of nursing home residents with low care needs
14.	Percent of adults age 18+ with disabilities in the community usually or always getting needed support
15.	Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life
16.	Rate of employment for adults with ADL disability ages 18–64 relative to rate of employment for adults without ADL disability ages 18–64
17.	Percent of high-risk nursing home residents with pressure sores 2008
18.	Percent of long-stay nursing home residents who were physically restrained
19.	Nursing home staffing turnover: ratio of employee terminations to the average number of active employees
20.	Percent of long-stay nursing home residents with a hospital admission 2008
21.	Percent of home health episodes of care in which interventions to prevent pressure sores were included in the plan of care for at-risk patients
22.	Percent of home health patients with a hospital admission 2008
23.	Percent of caregivers usually or always getting needed support 2009
24.	Legal and system supports for caregivers (composite indicator, scale 0–12)
25.	Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks)

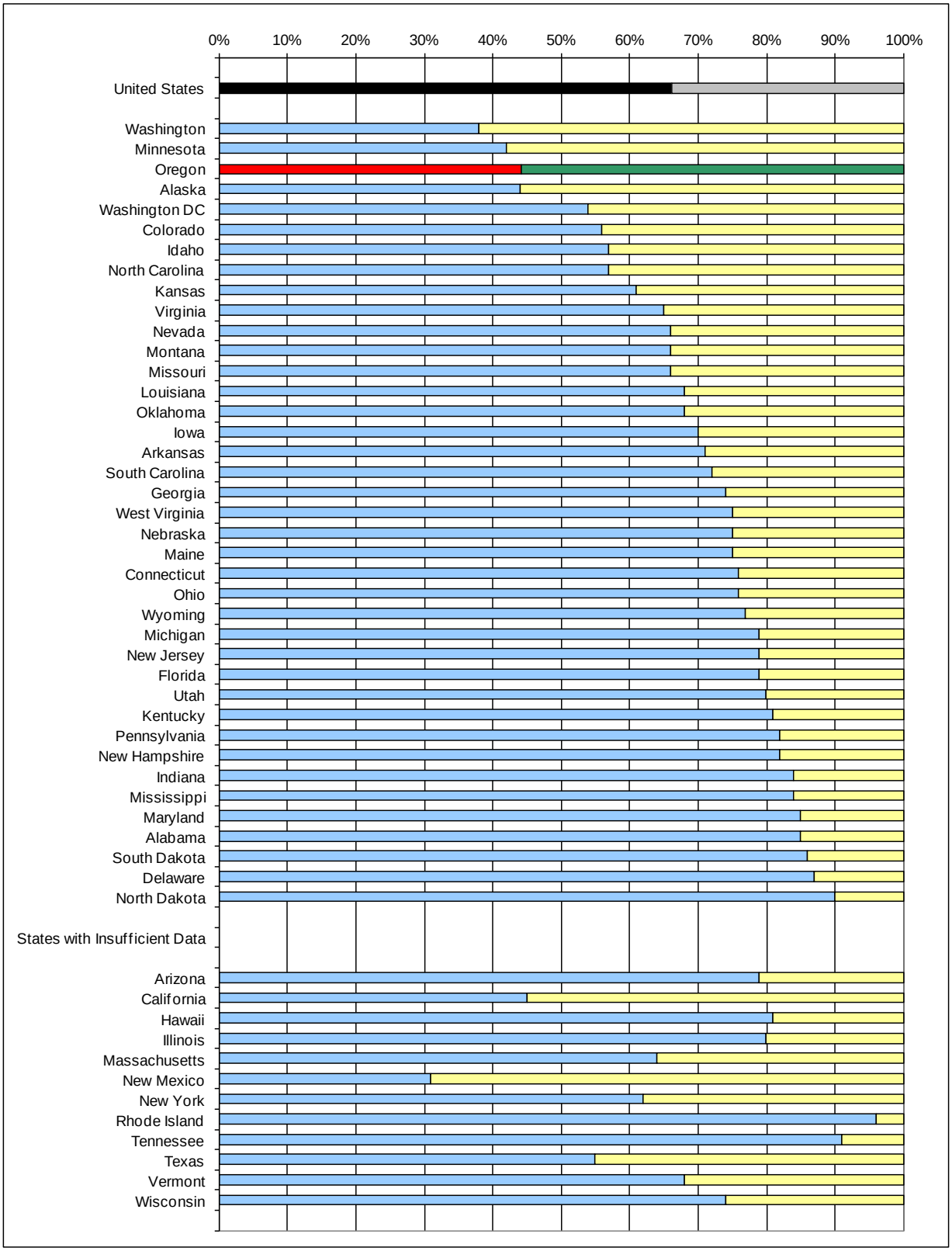
Source: LTSS Scorecard. Exhibit A-2

Table A-2: LTSS Scorecard Summary of Indicator Rankings by State

			Number of indicators for which State was ranked in each category						
Overall Rank	**State**	**Number of indicators**	**Top 5 States**	**Top Quar-tile**	**2nd Quar-tile**	**3rd Quar-tile**	**Bottom Quartile**	**Bottom 5 States**
1	Minnesota	25	11	15	6	3	1	1
2	Washington	25	7	12	9	2	2	1
3	**Oregon**	**25**	**9**	**13**	**4**	**6**	**2**	**0**
4	Hawaii	24	6	12	2	8	2	0
5	Wisconsin	25	1	10	9	2	4	0
6	Iowa	25	4	10	6	5	4	1
7	Colorado	25	2	7	10	8	0	0
8	Maine	23	4	8	8	4	3	3
9	Kansas	25	2	7	9	6	3	1
10	District of Columbia	20	6	11	2	3	4	4
11	Connecticut	24	2	6	9	6	3	1
12	Virginia	23	1	6	6	9	2	0
13	Missouri	25	2	5	9	8	3	1
14	Nebraska	25	4	7	6	9	3	1
15	Arizona	22	2	2	9	7	4	0
15	California	25	4	10	3	4	8	2
17	Alaska	19	9	12	1	2	4	3
18	North Dakota	24	5	11	4	4	5	3
19	Idaho	25	2	8	6	5	6	4
20	Vermont	25	3	9	5	5	6	0
20	Wyoming	25	3	7	7	6	5	2
22	New Jersey	25	1	7	3	9	6	2
23	Illinois	25	3	7	5	7	6	3
24	Maryland	25	1	4	11	5	5	0
24	North Carolina	25	1	7	3	11	4	1
26	New Mexico	24	3	6	10	6	2	0
27	New Hampshire	25	3	5	8	8	4	1
28	Texas	25	0	6	5	7	7	2
29	South Dakota	25	3	5	9	3	8	4
30	Massachusetts	25	2	4	11	6	4	0
31	Michigan	25	1	4	9	8	4	1
32	Delaware	25	1	6	5	8	6	4
33	Montana	24	1	7	6	5	6	3
34	Rhode Island	25	3	8	5	5	7	6
35	Ohio	25	0	2	9	9	5	2
36	Utah	25	5	8	4	6	7	6
37	Arkansas	25	0	5	6	5	9	4
38	South Carolina	25	3	3	8	6	8	1
39	Pennsylvania	24	2	3	8	7	6	0
40	Nevada	25	1	3	7	7	8	3
41	New York	24	2	5	5	6	8	4
42	Georgia	24	0	3	7	9	5	2
43	Louisiana	25	0	5	4	7	9	7
44	Florida	25	1	6	2	6	11	2
45	Tennessee	25	0	2	3	7	13	5
46	Kentucky	23	0	1	2	9	11	4
47	Indiana	24	0	3	4	7	10	3
48	Oklahoma	25	0	1	4	6	14	6
49	West Virginia	25	0	1	7	6	11	7
50	Alabama	25	0	2	5	5	13	7
51	Mississippi	25	0	3	1	5	16	10

Source: State Scorecard on LTSS

Figure A-1: Distribution of Medicaid Long-Term Care Expenditures by State for the Aged and Disabled, FY 2009



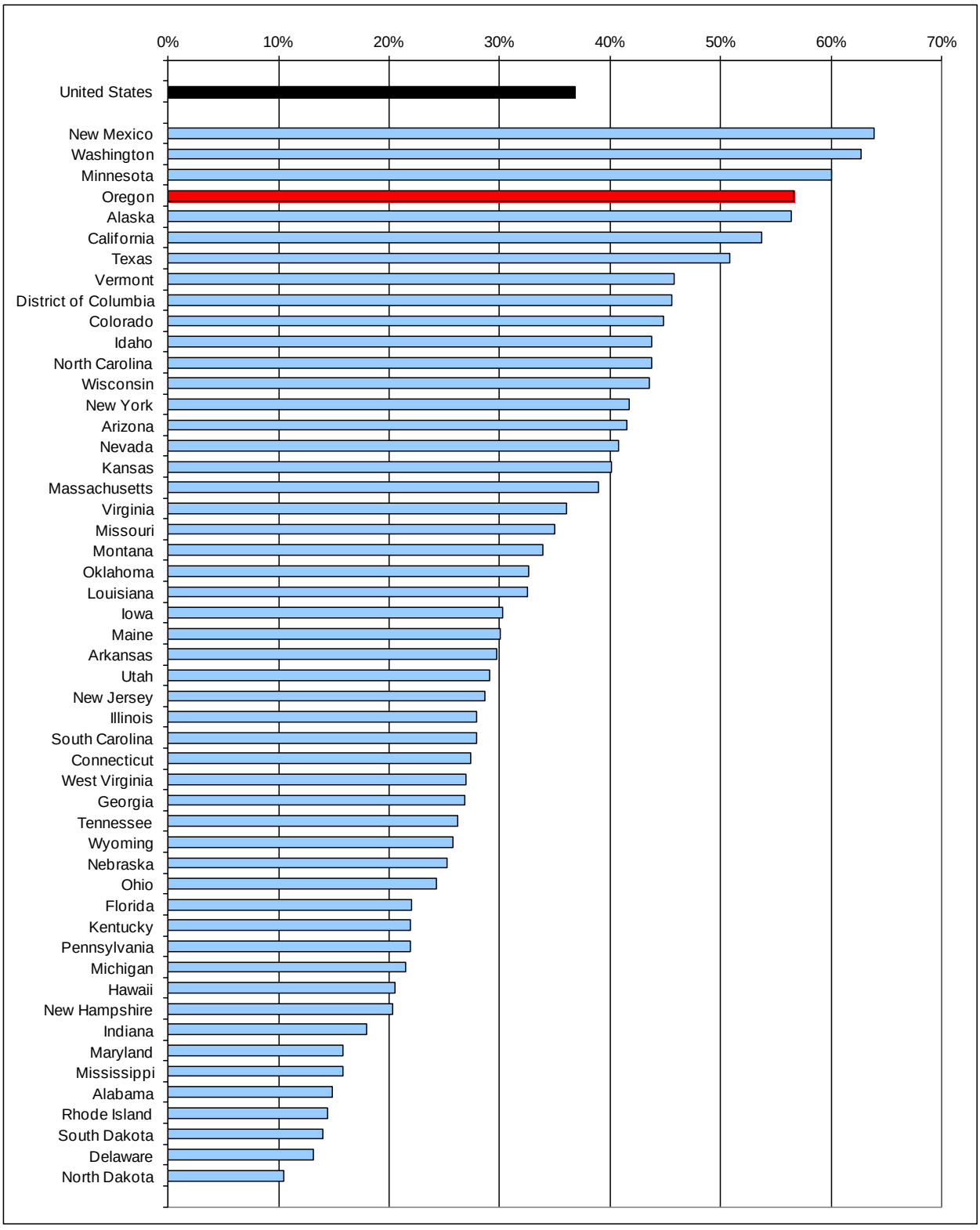
B. Burwell, et al. "Medicaid Long-Term Care Expenditures in FY 2009." Thomson Reuters. 2010.

TableA-3: Distribution of Medicaid Long-Term Care Expenditures by State for the Aged and Disabled, FY 2009

Rank	State	Institutional Expenditures	Percent	Community Expenditures	Percent	Total Expenditures
1	Washington	$582,533,776	38%	$949,931,834	62%	$1,532,465,610
2	Minnesota	$835,049,290	42%	$1,130,900,318	58%	$1,965,949,608
3	Oregon	$341,814,529	44%	$439,155,051	56%	$780,969,580
4	Alaska	$118,855,368	44%	$149,610,053	56%	$268,465,421
5	Washington DC	$197,295,629	54%	$165,125,042	46%	$362,420,671
6	Colorado	$548,943,656	56%	$423,860,469	44%	$972,804,125
7	Idaho	$157,450,986	57%	$120,404,973	43%	$277,855,959
8	North Carolina	$1,287,569,396	57%	$963,771,711	43%	$2,251,341,107
9	Kansas	$375,257,360	61%	$243,677,332	39%	$618,934,692
10	Virginia	$769,097,900	65%	$416,041,021	35%	$1,185,138,921
11	Nevada	$162,315,188	66%	$83,804,924	34%	$246,120,112
12	Montana	$158,289,932	66%	$81,358,945	34%	$239,648,877
13	Missouri	$870,160,260	66%	$441,886,582	34%	$1,312,046,842
14	Louisiana	$744,256,941	68%	$357,714,619	32%	$1,101,971,560
15	Oklahoma	$529,503,379	68%	$253,853,139	32%	$783,356,518
16	Iowa	$460,741,103	70%	$194,021,121	30%	$654,762,224
17	Arkansas	$572,795,228	71%	$234,191,383	29%	$806,986,611
18	South Carolina	$513,252,844	72%	$198,774,748	28%	$712,027,592
19	Georgia	$1,149,417,503	74%	$403,638,304	26%	$1,553,055,807
20	West Virginia	$459,260,145	75%	$157,169,373	25%	$616,429,518
21	Nebraska	$317,950,416	75%	$105,140,869	25%	$423,091,285
22	Maine	$254,107,927	75%	$82,625,425	25%	$336,733,352
23	Connecticut	$1,239,838,546	76%	$397,947,447	24%	$1,637,785,993
24	Ohio	$2,561,349,803	76%	$811,105,245	24%	$3,372,455,048
25	Wyoming	$72,834,891	77%	$22,295,435	23%	$95,130,326
26	Michigan	$1,534,989,618	79%	$419,889,567	21%	$1,954,879,185
27	New Jersey	$1,943,333,776	79%	$524,373,613	21%	$2,467,707,389
28	Florida	$2,402,791,045	79%	$620,249,548	21%	$3,023,040,593
29	Utah	$149,490,224	80%	$36,470,943	20%	$185,961,167
30	Kentucky	$827,779,576	81%	$198,541,349	19%	$1,026,320,925
31	Pennsylvania	$3,605,567,586	82%	$788,781,097	18%	$4,394,348,683
32	New Hampshire	$314,619,705	82%	$67,562,336	18%	$382,182,041
33	Indiana	$1,206,919,909	84%	$233,402,284	16%	$1,440,322,193
34	Mississippi	$727,351,102	84%	$136,369,526	16%	$863,720,628
35	Maryland	$1,061,474,895	85%	$186,522,329	15%	$1,247,997,224
36	Alabama	$938,113,372	85%	$164,789,672	15%	$1,102,903,044
37	South Dakota	$142,270,277	86%	$23,197,869	14%	$165,468,146
38	Delaware	$185,844,847	87%	$26,591,899	13%	$212,436,746
39	North Dakota	$173,635,728	90%	$19,628,886	10%	$193,264,614
	States with Insufficient Data to Determine Ranking					
	Arizona	$33,119,468	79%	$9,033,182	21%	$42,152,650
	California	$3,945,503,021	45%	$4,842,900,346	55%	$8,788,403,367
	Hawaii	$104,752,171	81%	$24,932,237	19%	$129,684,408
	Illinois	$1,631,062,689	80%	$402,113,343	20%	$2,033,176,032
	Massachusetts	$1,616,521,340	64%	$906,970,674	36%	$2,523,492,014
	New Mexico	$59,720,513	31%	$131,820,009	69%	$191,540,522
	New York	$7,618,853,959	62%	$4,693,708,149	38%	$12,312,562,108
	Rhode Island	$294,059,457	96%	$13,509,736	4%	$307,569,193
	Tennessee	$975,022,948	91%	$94,717,706	9%	$1,069,740,654
	Texas	$2,151,950,372	55%	$1,727,093,611	45%	$3,879,043,983
	Vermont	$118,215,099	68%	$56,856,875	32%	$175,071,974
	Wisconsin	$1,098,776,448	74%	$385,338,016	26%	$1,484,114,464
	United States	$50,141,681,141	66%	$25,563,370,165	34%	$75,705,051,306

B. Burwell, et al. "Medicaid Long-Term Care Expenditures in FY 2009." Thomson Reuters. 2010.

Figure A-2: Percent of Medicaid & State-Funded LTSS Spending for Older People and Adults with Physical Disabilities Going to HCBS by State, 2009

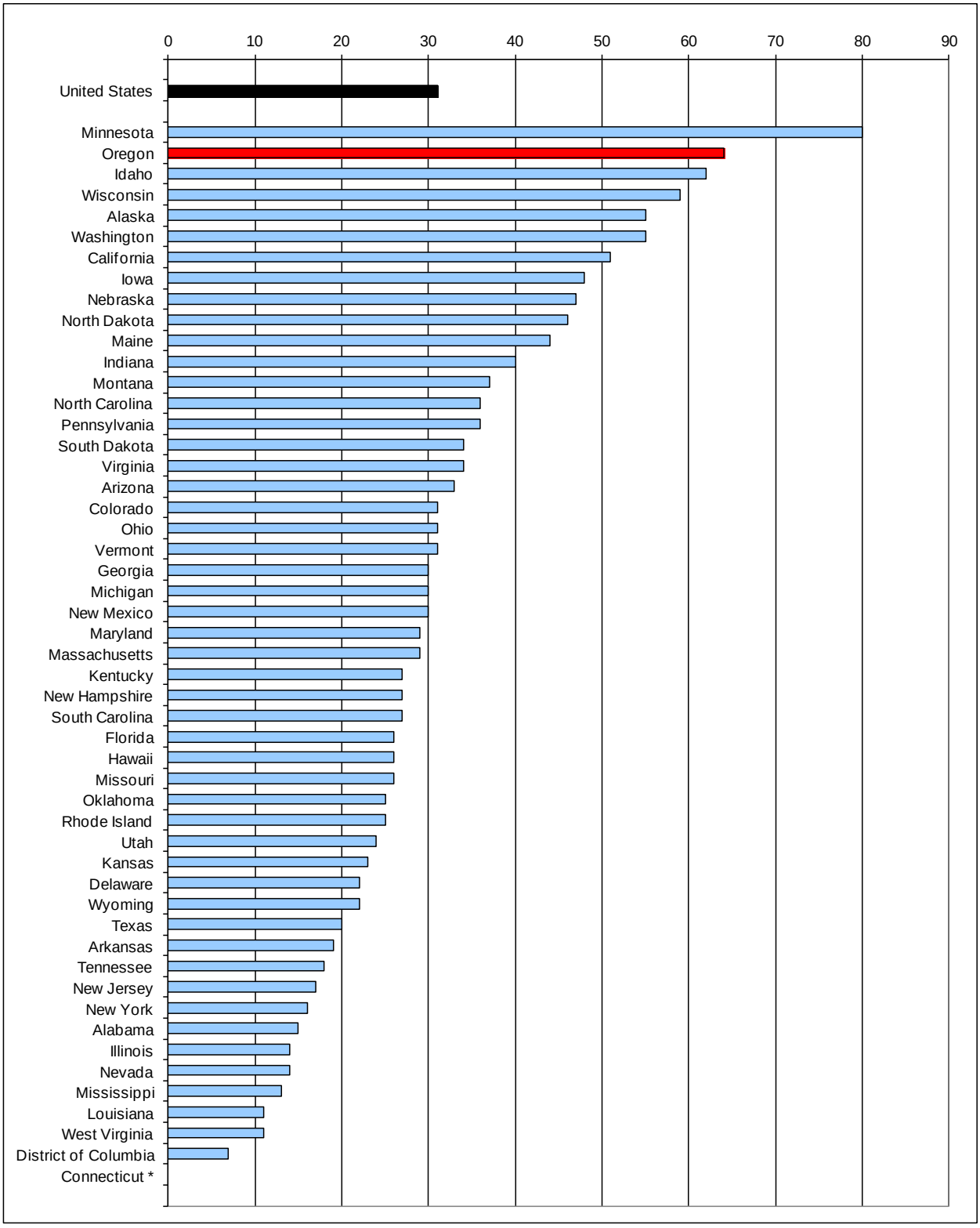


Source: State Scorecard on LTSS

Table A-4: Percent of Medicaid & State-Funded LTSS Spending for Older People and Adults with Physical Disabilities Going to HCBS by State, 2009

State	2009	Rank
New Mexico	63.9%	1
Washington	62.7%	2
Minnesota	60.0%	3
Oregon	**56.6%**	**4**
Alaska	56.4%	5
California	53.7%	6
Texas	50.8%	7
Vermont	45.8%	8
District of Columbia	45.6%	9
Colorado	44.8%	10
Idaho	43.8%	11
North Carolina	43.8%	11
Wisconsin	43.5%	13
New York	41.7%	14
Arizona	41.5%	15
Nevada	40.8%	16
Kansas	40.1%	17
Massachusetts	38.9%	18
United States	**36.8%**	
Virginia	36.1%	19
Missouri	35.0%	20
Montana	33.9%	21
Oklahoma	32.6%	22
Louisiana	32.5%	23
Iowa	30.3%	24
Maine	30.1%	25
Arkansas	29.7%	26
Utah	29.1%	27
New Jersey	28.7%	28
Illinois	27.9%	29
South Carolina	27.9%	29
Connecticut	27.4%	31
West Virginia	27.0%	32
Georgia	26.8%	33
Tennessee	26.2%	34
Wyoming	25.8%	35
Nebraska	25.2%	36
Ohio	24.3%	37
Florida	22.0%	38
Kentucky	21.9%	39
Pennsylvania	21.9%	39
Michigan	21.5%	41
Hawaii	20.5%	42
New Hampshire	20.3%	43
Indiana	18.0%	44
Maryland	15.8%	45
Mississippi	15.8%	45
Alabama	14.9%	47
Rhode Island	14.4%	48
South Dakota	14.0%	49
Delaware	13.2%	50
North Dakota	10.5%	51
Source: State Scorecard on LTSS		

Figure A-3: Assisted Living and Residential Care Units per 1,000 Population Age 65+ by State, 2010



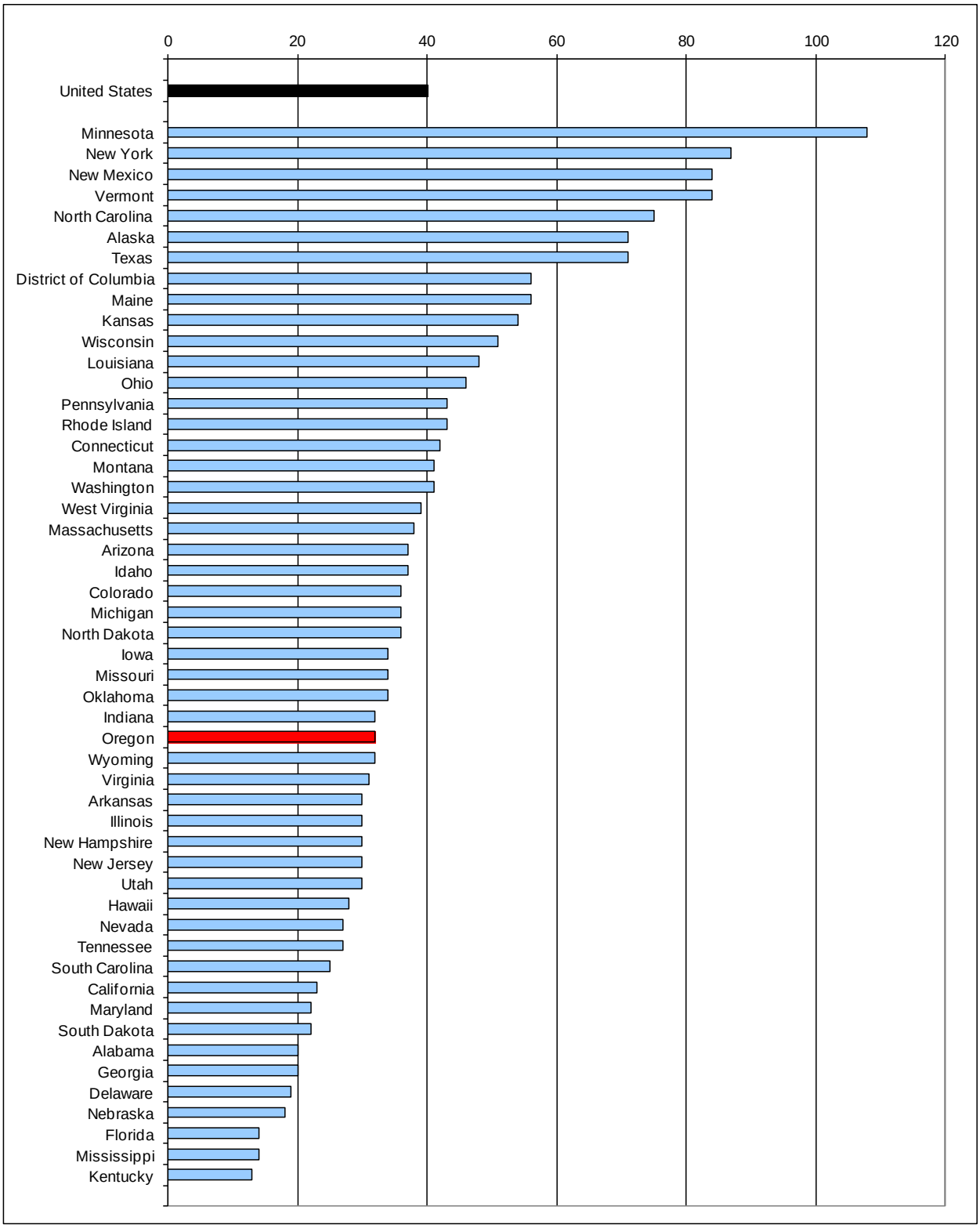
Source: State Scorecard on LTSS

Table A-5: Assisted Living and Residential Care Units per 1,000 Population Age 65+ by State, 2010

State	2010 Number of Units/1,000 65+	Rank
Minnesota	80	1
Oregon	64	2
Idaho	62	3
Wisconsin	59	4
Alaska	55	5
Washington	55	5
California	51	7
Iowa	48	8
Nebraska	47	9
North Dakota	46	10
Maine	44	11
Indiana	40	12
Montana	37	13
North Carolina	36	14
Pennsylvania	36	14
South Dakota	34	16
Virginia	34	16
Arizona	33	18
Colorado	31	19
Ohio	31	19
Vermont	31	19
United States		
Georgia	30	22
Michigan	30	22
New Mexico	30	22
Maryland	29	25
Massachusetts	29	25
Kentucky	27	27
New Hampshire	27	27
South Carolina	27	27
Florida	26	30
Hawaii	26	30
Missouri	26	30
Oklahoma	25	33
Rhode Island	25	33
Utah	24	35
Kansas	23	36
Delaware	22	37
Wyoming	22	37
Texas	20	39
Arkansas	19	40
Tennessee	18	41
New Jersey	17	42
New York	16	43
Alabama	15	44
Illinois	14	45
Nevada	14	45
Mississippi	13	47
Louisiana	11	48
West Virginia	11	48
District of Columbia	7	50
Connecticut	NA	NA

Source: State Scorecard on LTSS

Figure A-4: Home Health and Personal Care Aides per 1,000 Population Age 65+ by State, 2009



Source: State Scorecard on LTSS

Table A-6: Home Health and Personal Care Aides per 1,000 Population Age 65+ by State, 2009

State	2009	Rank
Minnesota	108	1
New York	87	2
New Mexico	84	3
Vermont	84	3
North Carolina	75	5
Alaska	71	6
Texas	71	6
District of Columbia	56	8
Maine	56	8
Kansas	54	10
Wisconsin	51	11
Louisiana	48	12
Ohio	46	13
Pennsylvania	43	14
Rhode Island	43	14
Connecticut	42	16
Montana	41	17
Washington	41	17
United States	40	
West Virginia	39	19
Massachusetts	38	20
Arizona	37	21
Idaho	37	21
Colorado	36	23
Michigan	36	23
North Dakota	36	23
Iowa	34	26
Missouri	34	26
Oklahoma	34	26
Indiana	32	29
Oregon	32	29
Wyoming	32	29
Virginia	31	32
Arkansas	30	33
Illinois	30	33
New Hampshire	30	33
New Jersey	30	33
Utah	30	33
Hawaii	28	38
Nevada	27	39
Tennessee	27	39
South Carolina	25	41
California	23	42
Maryland	22	43
South Dakota	22	43
Alabama	20	45
Georgia	20	45
Delaware	19	47
Nebraska	18	48
Florida	14	49
Mississippi	14	49
Kentucky	13	51
Source: State Scorecard on LTSS		

TableA-7: Nursing Home Occupancy Rates by State (% Beds Occupied) Selected Years

State	1995	2000	2009	2010
United States	**84.5**	**82.4**	**82.2**	**82.0**
Alabama	92.9	91.4	86.3	86.2
Alaska	77.9	72.5	88.4	94.0
Arizona	76.6	75.9	74.1	72.2
Arkansas	69.5	75.1	72.9	72.8
California	78.3	80.8	84.4	84.7
Colorado	85.7	84.2	82.0	80.5
Connecticut	91.2	91.4	89.6	88.8
Delaware	80.6	79.5	85.9	83.1
District of Columbia	80.3	92.9	91.5	93.5
Florida	85.1	82.8	87.5	87.5
Georgia	94.3	91.8	87.3	86.8
Hawaii	96.0	88.8	90.6	90.2
Idaho	81.7	75.1	71.6	71.3
Illinois	81.1	75.5	74.1	74.4
Indiana	74.5	74.6	68.2	67.9
Iowa	68.8	78.9	77.5	77.5
Kansas	83.8	82.1	74.0	74.2
Kentucky	89.1	89.7	89.7	89.2
Louisiana	86.0	77.9	70.4	69.8
Maine	92.9	88.5	91.2	90.0
Maryland	87.0	81.4	86.0	85.6
Massachusetts	91.3	88.9	88.0	87.2
Michigan	87.5	84.1	85.3	84.8
Minnesota	93.8	92.1	91.3	91.0
Mississippi	94.9	92.7	88.3	88.7
Missouri	75.7	70.4	67.9	68.3
Montana	89.0	77.9	72.0	70.7
Nebraska	89.0	83.8	77.9	78.6
Nevada	91.2	65.9	82.2	80.9
New Hampshire	92.8	91.3	89.7	90.1
New Jersey	91.9	87.8	89.5	89.9
New Mexico	86.8	89.2	82.4	82.1
New York	96.0	93.7	90.2	92.4
North Carolina	92.7	88.6	85.2	83.8
North Dakota	96.4	91.2	91.1	87.4
Ohio	73.9	78.0	85.9	85.2
Oklahoma	77.8	70.3	65.6	66.5
Oregon	**84.1**	**74.0**	**62.6**	**61.8**
Pennsylvania	91.6	88.2	90.7	91.2
Rhode Island	91.8	88.0	91.2	91.4
South Carolina	87.3	86.9	89.9	88.0
South Dakota	95.5	90.0	93.9	81.9
Tennessee	91.5	89.9	85.7	85.6
Texas	72.6	68.2	70.2	69.7
Utah	82.1	74.5	66.8	64.9
Vermont	96.2	89.5	90.5	89.5
Virginia	93.5	88.5	88.8	88.1
Washington	87.7	81.7	82.5	82.7
West Virginia	93.7	90.5	88.7	88.2
Wisconsin	90.2	83.9	86.7	84.8
Wyoming	87.7	83.5	80.0	81.9

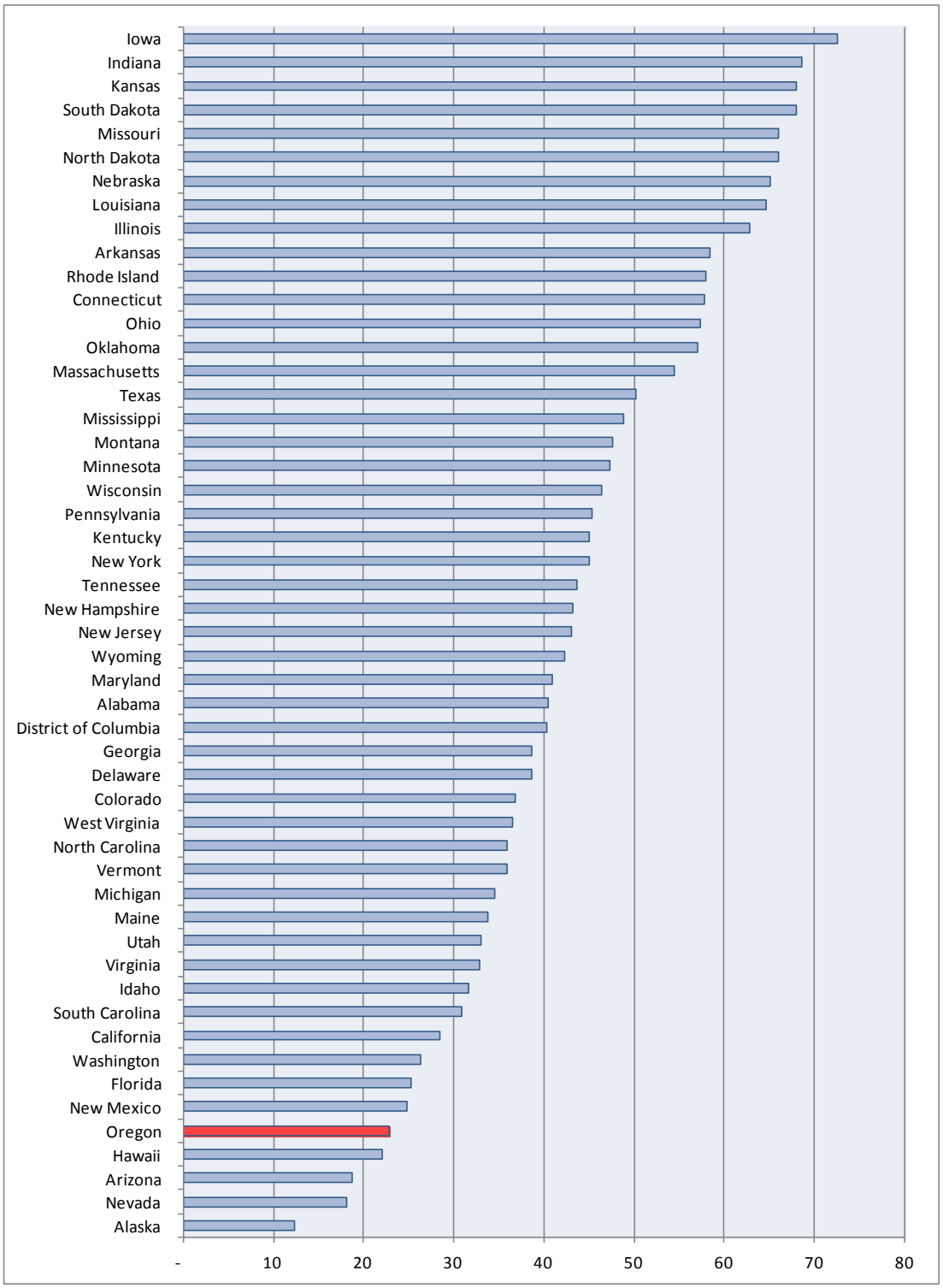
Source: US Census Data

Table A-8: Nursing Home Occupancy Rates by State (% Beds Occupied) 1995 and 2010 - Lowest to Highest Rates

State	1995	State	2010
United States	**84.5**	**United States**	**82.0**
Iowa	68.8	**Oregon**	**61.8**
Arkansas	69.5	Utah	64.9
Texas	72.6	Oklahoma	66.5
Ohio	73.9	Indiana	67.9
Indiana	74.5	Missouri	68.3
Missouri	75.7	Texas	69.7
Arizona	76.6	Louisiana	69.8
Oklahoma	77.8	Montana	70.7
Alaska	77.9	Idaho	71.3
California	78.3	Arizona	72.2
District of Columbia	80.3	Arkansas	72.8
Delaware	80.6	Kansas	74.2
Illinois	81.1	Illinois	74.4
Idaho	81.7	Iowa	77.5
Utah	82.1	Nebraska	78.6
Kansas	83.8	Colorado	80.5
Oregon	**84.1**	Nevada	80.9
Florida	85.1	South Dakota	81.9
Colorado	85.7	Wyoming	81.9
Louisiana	86.0	New Mexico	82.1
New Mexico	86.8	Washington	82.7
Maryland	87.0	Delaware	83.1
South Carolina	87.3	North Carolina	83.8
Michigan	87.5	California	84.7
Washington	87.7	Michigan	84.8
Wyoming	87.7	Wisconsin	84.8
Montana	89.0	Ohio	85.2
Nebraska	89.0	Maryland	85.6
Kentucky	89.1	Tennessee	85.6
Wisconsin	90.2	Alabama	86.2
Connecticut	91.2	Georgia	86.8
Nevada	91.2	Massachusetts	87.2
Massachusetts	91.3	North Dakota	87.4
Tennessee	91.5	Florida	87.5
Pennsylvania	91.6	South Carolina	88.0
Rhode Island	91.8	Virginia	88.1
New Jersey	91.9	West Virginia	88.2
North Carolina	92.7	Mississippi	88.7
New Hampshire	92.8	Connecticut	88.8
Alabama	92.9	Kentucky	89.2
Maine	92.9	Vermont	89.5
Virginia	93.5	New Jersey	89.9
West Virginia	93.7	Maine	90.0
Minnesota	93.8	New Hampshire	90.1
Georgia	94.3	Hawaii	90.2
Mississippi	94.9	Minnesota	91.0
South Dakota	95.5	Pennsylvania	91.2
Hawaii	96.0	Rhode Island	91.4
New York	96.0	New York	92.4
Vermont	96.2	District of Columbia	93.5
North Dakota	96.4	Alaska	94.0

Source: US Census Data

Figure A-5: Number of Nursing Home Beds/1,000 Population 65+, 2010



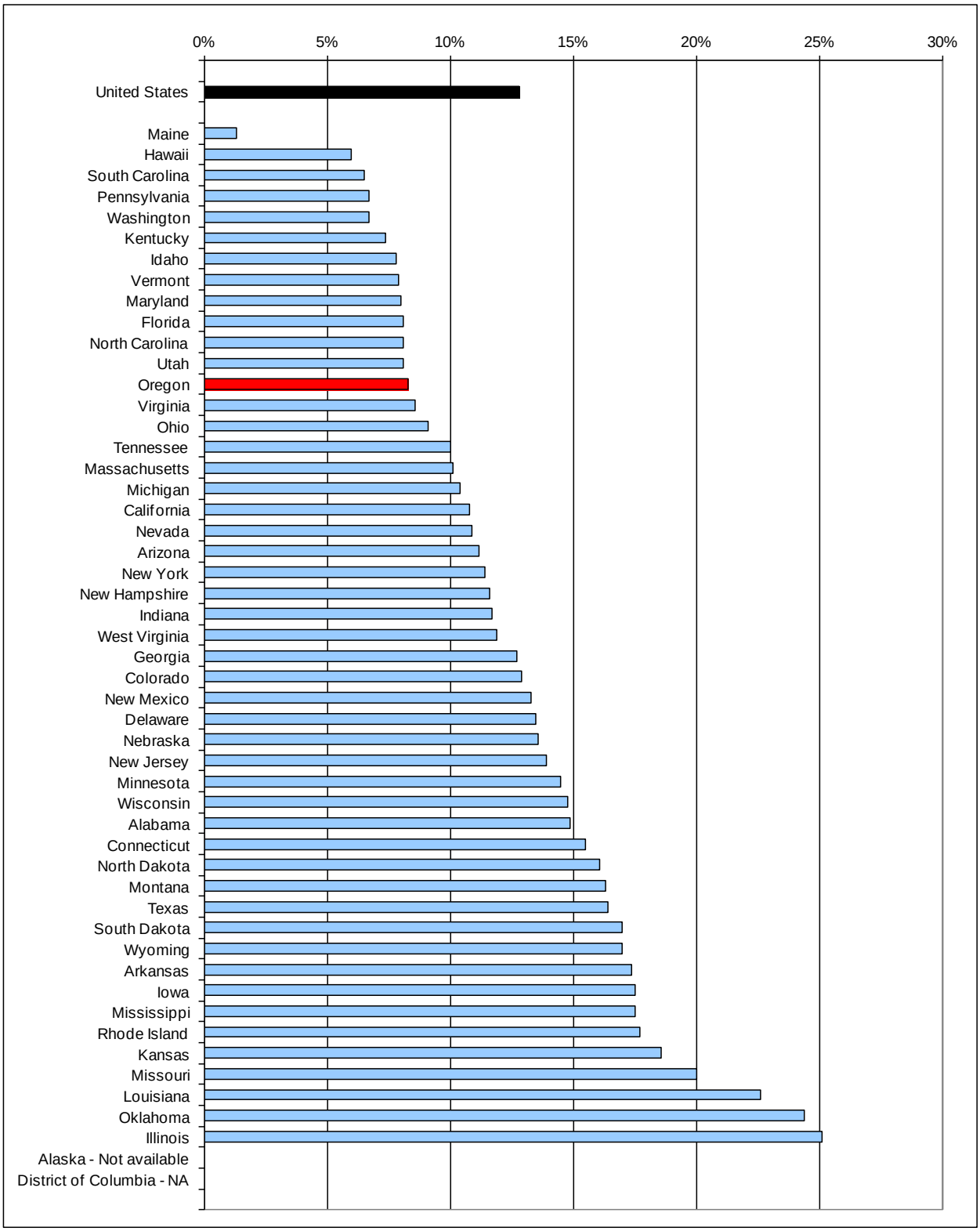
Source: US Census Data

Table A-9: Number of Nursing Home Beds/1,000 Population 65+,2010

State	2010 Population Age 65+	2010 Nursing Home Beds	Beds/1,000 65+
Alaska	54,938	682	12.4
Nevada	324,359	5,856	18.1
Arizona	881,831	16,460	18.7
Hawaii	195,138	4,303	22.1
Oregon	533,533	12,218	22.9
New Mexico	272,255	6,769	24.9
Florida	3,259,602	82,226	25.2
Washington	827,677	21,837	26.4
California	4,246,514	121,167	28.5
South Carolina	631,874	19,474	30.8
Idaho	194,668	6,153	31.6
Virginia	976,937	32,152	32.9
Utah	249,462	8,255	33.1
Maine	211,080	7,127	33.8
Michigan	1,361,530	47,054	34.6
North Carolina	1,234,079	44,392	36.0
Vermont	91,078	3,276	36.0
West Virginia	297,404	10,840	36.4
Colorado	549,625	20,259	36.9
Delaware	129,277	4,990	38.6
Georgia	1,032,035	39,960	38.7
District of Columbia	68,809	2,775	40.3
Alabama	657,792	26,656	40.5
Maryland	707,642	29,004	41.0
Wyoming	70,090	2,965	42.3
New Hampshire	178,268	7,692	43.1
New Jersey	1,185,993	51,101	43.1
Tennessee	853,462	37,279	43.7
Kentucky	578,227	26,063	45.1
New York	2,617,943	117,984	45.1
Pennsylvania	1,959,307	88,829	45.3
Wisconsin	777,314	36,113	46.5
Minnesota	683,121	32,339	47.3
Montana	146,742	6,991	47.6
Mississippi	380,407	18,589	48.9
Texas	2,601,886	130,665	50.2
Massachusetts	902,724	49,175	54.5
Oklahoma	506,714	28,932	57.1
Ohio	1,622,015	93,043	57.4
Connecticut	506,559	29,255	57.8
Rhode Island	151,881	8,802	58.0
Arkansas	419,981	24,548	58.5
Illinois	1,609,213	101,061	62.8
Louisiana	557,857	36,098	64.7
Nebraska	246,677	16,065	65.1
North Dakota	97,477	6,438	66.0
Missouri	838,294	55,393	66.1
South Dakota	116,581	7,932	68.0
Kansas	376,116	25,598	68.1
Indiana	841,108	57,721	68.6
Iowa	452,888	32,842	72.5

Sources: US Census Bureau. Table 117 Nursing homes, beds, residents, and occupancy rates, by state: United States, selected years 1995-2010. Calculation: HMA.

Figure A-6: Percent of Nursing Home Residents With Low Care Needs by State, 2007



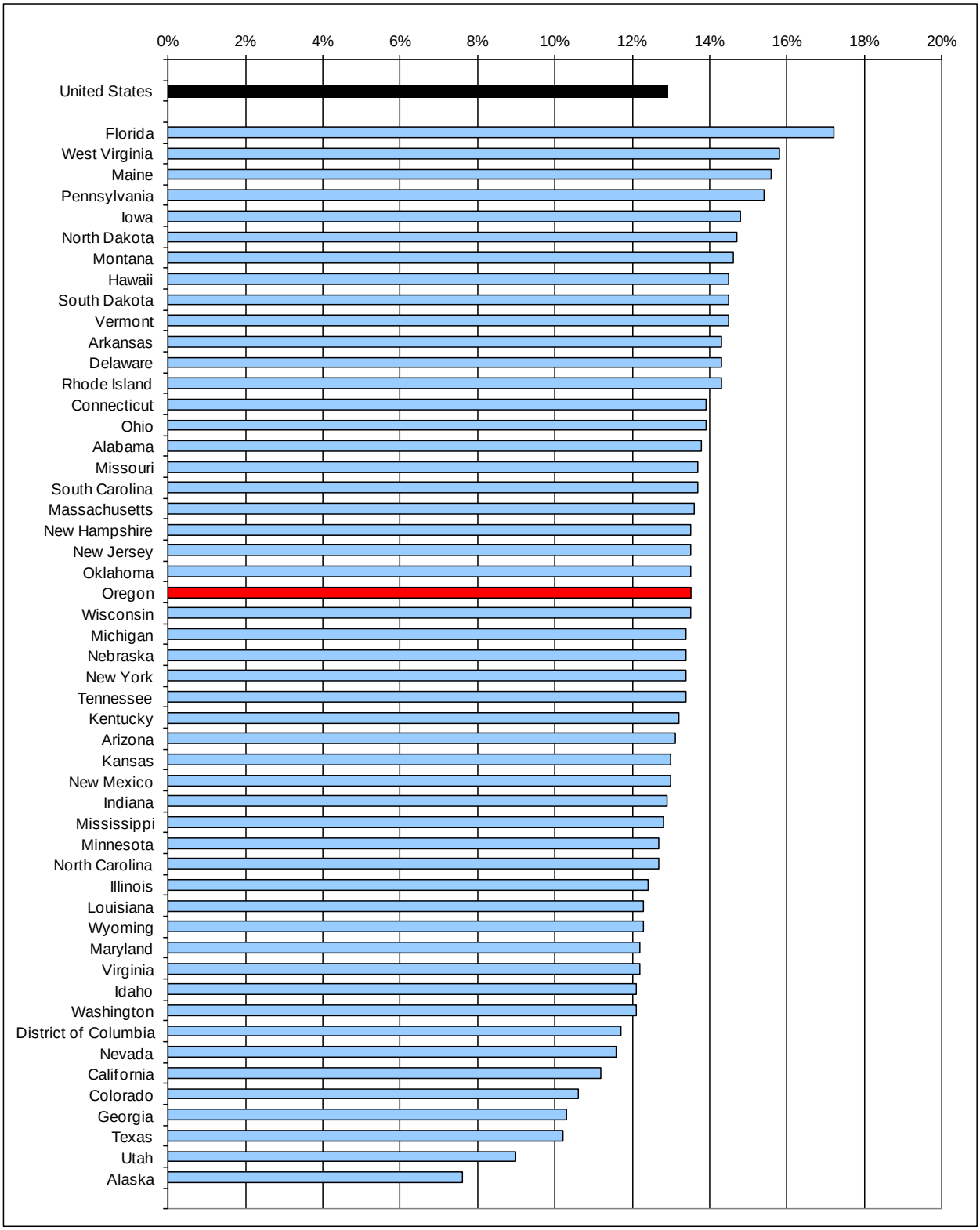
Source: State Scorecard on LTSS

Table A-10: Percent of Nursing Home Residents With Low Care Needs by State, 2007

State	2007	Rank
Maine	1.3%	1
Hawaii	6.0%	2
South Carolina	6.5%	3
Pennsylvania	6.7%	4
Washington	6.7%	4
Kentucky	7.4%	6
Idaho	7.8%	7
Vermont	7.9%	8
Maryland	8.0%	9
Florida	8.1%	10
North Carolina	8.1%	10
Utah	8.1%	10
Oregon	8.3%	13
Virginia	8.6%	14
Ohio	9.1%	15
Tennessee	10.0%	16
Massachusetts	10.1%	17
Michigan	10.4%	18
California	10.8%	19
Nevada	10.9%	20
Arizona	11.2%	21
New York	11.4%	22
New Hampshire	11.6%	23
Indiana	11.7%	24
West Virginia	11.9%	25
United States	12.8%	
Georgia	12.7%	26
Colorado	12.9%	27
New Mexico	13.3%	28
Delaware	13.5%	29
Nebraska	13.6%	30
New Jersey	13.9%	31
Minnesota	14.5%	32
Wisconsin	14.8%	33
Alabama	14.9%	34
Connecticut	15.5%	35
North Dakota	16.1%	36
Montana	16.3%	37
Texas	16.4%	38
South Dakota	17.0%	39
Wyoming	17.0%	39
Arkansas	17.4%	41
Iowa	17.5%	42
Mississippi	17.5%	42
Rhode Island	17.7%	44
Kansas	18.6%	45
Missouri	20.0%	46
Louisiana	22.6%	47
Oklahoma	24.4%	48
Illinois	25.1%	49
Alaska	Not available	Not available
District of Columbia	Not available	Not available

Source: State Scorecard on LTSS

Figure A-7: Population 65+ by State, 2009

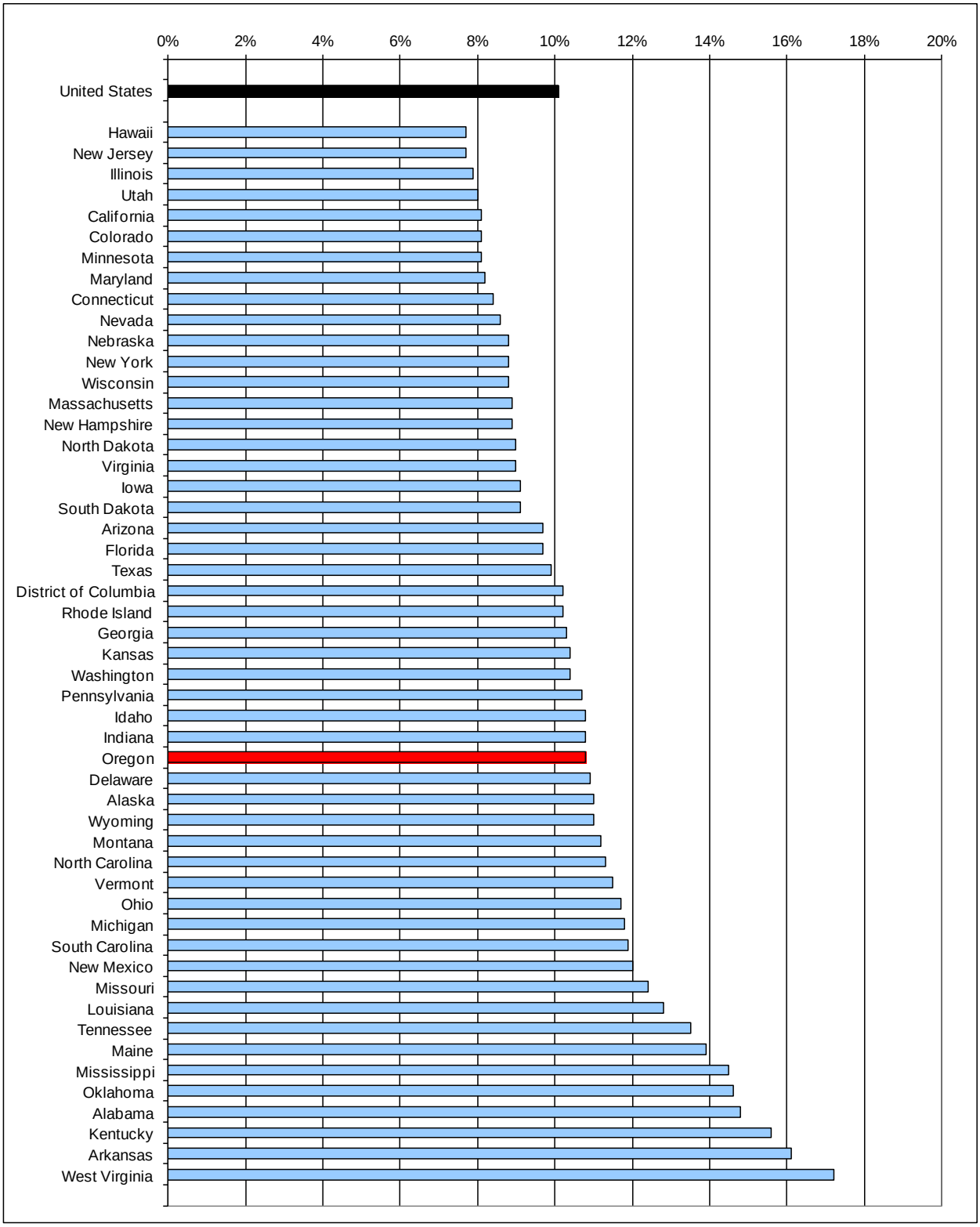


Source: State Scorecard on LTSS

Table A-11: Population 65+ by State, 2009

State	Percent Age 65+	Rank
Florida	17.2%	1
West Virginia	15.8%	2
Maine	15.6%	3
Pennsylvania	15.4%	4
Iowa	14.8%	5
North Dakota	14.7%	6
Montana	14.6%	7
Hawaii	14.5%	8
South Dakota	14.5%	9
Vermont	14.5%	10
Arkansas	14.3%	11
Delaware	14.3%	12
Rhode Island	14.3%	13
Connecticut	13.9%	14
Ohio	13.9%	15
Alabama	13.8%	16
Missouri	13.7%	17
South Carolina	13.7%	18
Massachusetts	13.6%	19
New Hampshire	13.5%	20
New Jersey	13.5%	21
Oklahoma	13.5%	22
Oregon	13.5%	23
Wisconsin	13.5%	24
Michigan	13.4%	25
Nebraska	13.4%	26
New York	13.4%	27
Tennessee	13.4%	28
Kentucky	13.2%	29
Arizona	13.1%	30
Kansas	13.0%	31
New Mexico	13.0%	32
United States	12.9%	
Indiana	12.9%	33
Mississippi	12.8%	34
Minnesota	12.7%	35
North Carolina	12.7%	36
Illinois	12.4%	37
Louisiana	12.3%	38
Wyoming	12.3%	39
Maryland	12.2%	40
Virginia	12.2%	41
Idaho	12.1%	42
Washington	12.1%	43
District of Columbia	11.7%	44
Nevada	11.6%	45
California	11.2%	46
Colorado	10.6%	47
Georgia	10.3%	48
Texas	10.2%	49
Utah	9.0%	50
Alaska	7.6%	51
Source: State Scorecard on LTSS		

Figure A-8: Proportion of People Age 18–64 with Any Disability by State, 2009

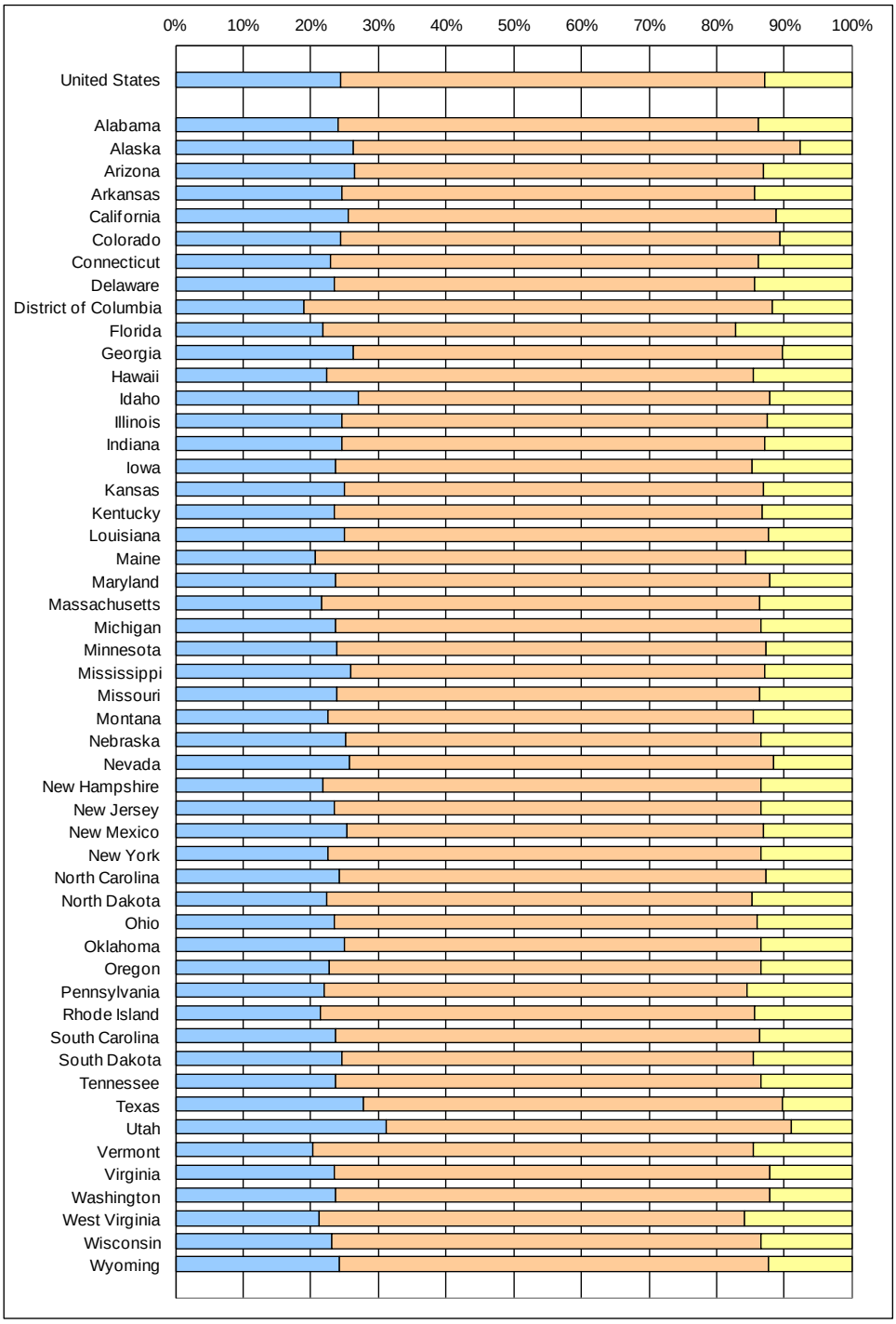


Source: State Scorecard on LTSS

Table A-12: Proportion of People Age 18–64 with Any Disability by State, 2009

State	Percentage	Rank
Hawaii	7.7%	1
New Jersey	7.7%	2
Illinois	7.9%	3
Utah	8.0%	4
California	8.1%	5
Colorado	8.1%	6
Minnesota	8.1%	7
Maryland	8.2%	8
Connecticut	8.4%	9
Nevada	8.6%	10
Nebraska	8.8%	11
New York	8.8%	12
Wisconsin	8.8%	13
Massachusetts	8.9%	14
New Hampshire	8.9%	15
North Dakota	9.0%	16
Virginia	9.0%	17
Iowa	9.1%	18
South Dakota	9.1%	19
Arizona	9.7%	20
Florida	9.7%	21
Texas	9.9%	22
United States	10.1%	
District of Columbia	10.2%	23
Rhode Island	10.2%	24
Georgia	10.3%	25
Kansas	10.4%	26
Washington	10.4%	27
Pennsylvania	10.7%	28
Idaho	10.8%	29
Indiana	10.8%	30
Oregon	10.8%	31
Delaware	10.9%	32
Alaska	11.0%	33
Wyoming	11.0%	34
Montana	11.2%	35
North Carolina	11.3%	36
Vermont	11.5%	37
Ohio	11.7%	38
Michigan	11.8%	39
South Carolina	11.9%	40
New Mexico	12.0%	41
Missouri	12.4%	42
Louisiana	12.8%	43
Tennessee	13.5%	44
Maine	13.9%	45
Mississippi	14.5%	46
Oklahoma	14.6%	47
Alabama	14.8%	48
Kentucky	15.6%	49
Arkansas	16.1%	50
West Virginia	17.2%	51
Source: State Scorecard on LTSS		

Figure A-9: State Demographics: Age of Population) by State, 2009



Source: State Scorecard on LTSS

Table A-13: State Demographics: Age of Population by State, 2009

State	All Ages	Percent <Age 18	Percent Age 18-64	Percent Age 65+
United States	**307,006,550**	**24.3%**	**62.8%**	**12.9%**
Alabama	4,708,708	24.0%	62.2%	13.8%
Alaska	698,473	26.3%	66.2%	7.6%
Arizona	6,595,778	26.3%	60.6%	13.1%
Arkansas	2,889,450	24.6%	61.1%	14.3%
California	36,961,664	25.5%	63.2%	11.2%
Colorado	5,024,748	24.4%	64.9%	10.6%
Connecticut	3,518,288	23.0%	63.2%	13.9%
Delaware	885,122	23.4%	62.3%	14.3%
District of Columbia	599,657	19.0%	69.3%	11.7%
Florida	18,537,969	21.9%	60.9%	17.2%
Georgia	9,829,211	26.3%	63.4%	10.3%
Hawaii	1,295,178	22.4%	63.1%	14.5%
Idaho	1,545,801	27.1%	60.8%	12.1%
Illinois	12,910,409	24.6%	63.0%	12.4%
Indiana	6,423,113	24.7%	62.4%	12.9%
Iowa	3,007,856	23.7%	61.5%	14.8%
Kansas	2,818,747	25.0%	62.0%	13.0%
Kentucky	4,314,113	23.5%	63.3%	13.2%
Louisiana	4,492,076	25.0%	62.7%	12.3%
Maine	1,318,301	20.6%	63.8%	15.6%
Maryland	5,699,478	23.7%	64.1%	12.2%
Massachusetts	6,593,587	21.7%	64.7%	13.6%
Michigan	9,969,727	23.6%	63.0%	13.4%
Minnesota	5,266,214	23.9%	63.3%	12.7%
Mississippi	2,951,996	26.0%	61.2%	12.8%
Missouri	5,987,580	23.9%	62.4%	13.7%
Montana	974,989	22.5%	62.9%	14.6%
Nebraska	1,796,619	25.1%	61.5%	13.4%
Nevada	2,643,085	25.8%	62.6%	11.6%
New Hampshire	1,324,575	21.8%	64.6%	13.5%
New Jersey	8,707,739	23.5%	63.0%	13.5%
New Mexico	2,009,671	25.4%	61.6%	13.0%
New York	19,541,453	22.6%	64.0%	13.4%
North Carolina	9,380,884	24.3%	63.0%	12.7%
North Dakota	646,844	22.3%	63.1%	14.7%
Ohio	11,542,645	23.5%	62.6%	13.9%
Oklahoma	3,687,050	24.9%	61.6%	13.5%
Oregon	**3,825,657**	**22.8%**	**63.7%**	**13.5%**
Pennsylvania	12,604,767	22.0%	62.5%	15.4%
Rhode Island	1,053,209	21.5%	64.2%	14.3%
South Carolina	4,561,242	23.7%	62.6%	13.7%
South Dakota	812,383	24.6%	60.9%	14.5%
Tennessee	6,296,254	23.7%	62.9%	13.4%
Texas	24,782,302	27.8%	61.9%	10.2%
Utah	2,784,572	31.2%	59.8%	9.0%
Vermont	621,760	20.3%	65.2%	14.5%
Virginia	7,882,590	23.4%	64.4%	12.2%
Washington	6,664,195	23.6%	64.3%	12.1%
West Virginia	1,819,777	21.2%	63.0%	15.8%
Wisconsin	5,654,774	23.2%	63.4%	13.5%
Wyoming	544,270	24.3%	63.5%	12.3%

Source: State Scorecard on LTSS

Table A-14: 2011 Medicaid Provider Taxes

States	Hospitals		ICFs/MR-DD		NFs		MCOs		Other		Any Provider Tax	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
Alabama	X	X			X	X			X	X	X	X
Alaska												
Arizona							X	X			X	X
Arkansas	X	X	X	X	X	X					X	X
California		X	X	X	X	X			X	X	X	X
Colorado	X	X	X	X	X	X					X	X
Connecticut					X	X					X	X
Delaware												
District of Columbia	X	X	X	X	X	X	X	X			X	X
Florida	X	X	X	X	X	X					X	X
Georgia		X			X	X					X	X
Hawaii												
Idaho	X	X			X	X					X	X
Illinois	X	X	X	X	X	X					X	X
Indiana			X	X	X	X					X	X
Iowa		X	X	X	X	X					X	X
Kansas	X	X				X					X	X
Kentucky	X	X	X	X	X	X			X	X	X	X
Louisiana			X	X	X	X			X	X	X	X
Maine	X	X	X	X	X	X			X	X	X	X
Maryland	X	X	X	X	X	X	X	X			X	X
Massachusetts	X	X			X	X			X	X	X	X
Michigan	X	X			X	X				X	X	X
Minnesota	X	X	X	X	X	X	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X					X	X
Missouri	X	X	X	X	X	X			X	X	X	X
Montana	X	X	X	X	X	X					X	X
Nebraska			X	X							X	X
Nevada					X	X					X	X
New Hampshire	X	X			X	X					X	X
New Jersey	X	X	X	X	X	X	X	X	X	X	X	X
New Mexico							X	X	X	X	X	X
New York	X	X	X	X	X	X			X	X	X	X
North Carolina			X	X	X	X					X	X
North Dakota			X	X							X	X
Ohio	X	X	X	X	X	X					X	X
Oklahoma					X	X					X	X
Oregon	X	X			X	X	X		X70	X	X	X

[70] One percent tax on commercial insurance.

States	Hospitals		ICFs/MR-DD		NFs		MCOs		Other		Any Provider Tax	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
Pennsylvania	X	X	X	X	X	X	X	X			X	X
Rhode Island	X	X	X	X	X	X	X	X			X	X
South Carolina	X	X	X	X							X	X
South Dakota			X	X							X	X
Tennessee		X	X	X	X	X	X	X			X	X
Texas			X	X			X	X			X	X
Utah		X	X	X	X	X					X	X
Vermont	X	X	X	X	X	X			X	X	X	X
Virginia				X								X
Washington	X	X	X	X			X	X			X	X
West Virginia	X	X	X	X	X	X					X	X
Wisconsin	X	X	X	X	X	X			X	X	X	X
Wyoming												
Total	29	34	33	34	37	38	12	11	14	15	46	47

Source: Kaiser Commission on Medicaid and the Uninsured. Medicaid Financing Issues – Provider Taxes. May 2011.