Aging & Disability Services Division: Medicaid Long-term Care Program Audit

July 2008

LaVonne Griffin-Valade
Multnomah County Auditor

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We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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MEMORANDUM

Date: July 31, 2008

To: Ted Wheeler, Multnomah County Chair
Maria Rojo de Steffey, Commissioner, District 1
Jeff Cogen, Commissioner, District 2
Lisa Naito, Commissioner, District 3
Lonnie Roberts, Commissioner, District 4

From: LaVonne Griffin-Valade, County Auditor

Subject: Audit of Aging & Disabilities Services Medicaid Long-term Care Program

The attached report details our examination of the Medicaid Long-term Care Program which is managed by Aging & Disability Services (ADS), a division of the Department of County Human Services. This audit brings together data from multiple state and county sources with the objective of analyzing costs and determining if ADS is prepared to meet the increasing demand for services in the future.

In FY07, the Medicaid Long-term Care Program served more than 7,000 very low-income seniors and physically disabled adults. Over the next few decades, that number is projected to increase dramatically. The report details our analyses of demographic and service trends, provides an assessment of current data systems, and makes specific recommendations for using data more effectively to manage resources and plan for the ongoing and future needs of clients.

The report also reflects the many discussions we had with managers and staff, who helped us to gain an in-depth understanding of complex funding and service requirements, as well as the reality of serving these needy clients. We were impressed with the knowledge and professionalism of staff members we encountered.

We plan to conduct a formal follow-up to this report within the next 18 months to two years. We would like to again acknowledge the cooperation we received from ADS staff throughout the audit.

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Executive Summary

This audit of the Aging & Disability Services (ADS) Division examined the Medicaid Long-term Care (LTC) Program which serves very low-income seniors and disabled adults eligible for nursing home care. The goal of the Program is to provide clients with alternatives to nursing facilities so they are able to maintain some level of independence and live in their own homes or community-based settings for as long as possible.

Our review shows that the dedicated staff in the county's Medicaid LTC Program link thousands of vulnerable residents to crucial and cost-effective services each year. The Program has faced a number of hurdles in recent years as a result of funding reductions and the tightening of eligibility requirements. By and large, this has meant that some needy clients who once received more extensive services, no longer qualify for certain Program offerings, if they qualify for services at all. This has forced ADS to make difficult choices in their approach to serving this particularly vulnerable population. Our observations, analyses, and recommendations for improvement should be viewed in that context.

Our report includes discussion of placement options, placement trends, and demographic information about the Program population. For example, between July 1, 2002 and June 30, 2007, the Program served 15,264 individuals. Of those clients, 29% received in-home care during all the months they were served. That represents important success on the part of the Program. In monetary terms alone, the average cost-per-client of providing in-home care in Fiscal Year 2007 (FY07) was about $7,600, compared to the average cost of about $32,500 per client cared for in a nursing facility.

Our analysis further indicates caseload differences among the five branch offices responsible for case management of Program clients. The West Branch serves a higher percentage of younger, disabled clients than any other branch; the North/Northeast Branch works with the highest percentage of minority clients; and the East Branch serves the highest number of clients needing more assistance with basic daily living needs.

We examined new client intake and caseload trends and found that intakes and caseload numbers have declined in recent years, with the changes in the state's policy regarding eligibility. It is worth noting that the number of clients served is expected to grow considerably in the future with the rapidly expanding senior population. Responding to the expected increases in the demand for long-term care will require realignment in Program efforts. Further, ADS management reports that the acuity level of clients appears to have increased.

We found that ADS improved its compliance with requirements to determine eligibility within 45 days of intake and to complete annual assessments. However, we also identified problems with the quality and use of data. We found that ADS does not have ready access to the consistent and reliable information needed to manage the Program. In particular, data on clients' disabilities and mental health needs is limited. This effectively means that ADS cannot accurately describe its client population and workload, or strategically plan for service delivery. This is a problem of some significance because accurate and timely data would assist with more effective resource deployment and provide assurance that client needs are being met.

In addition, ADS cannot adequately track clients who participate in its Medicaid LTC Program. Although the data systems available to ADS are not designed to track clients, we were able to merge data and analyze client experiences over time. For instance, we saw that placement of younger, disabled clients in nursing homes has increased over the time period reviewed, despite the overall decline in the number of people with disabilities served by the Program. Under-

standing this and other client trend information is important because the increased movement of just a few clients to nursing home care can rapidly raise Program costs.

ADS also does not have a good system for assigning new cases to case managers, they lack consistent reporting practices for monitoring monthly activities, and they could better utilize available data to evaluate the efficiency and effectiveness of intake processes. The result is that caseloads vary within and across branches. However, ADS has limited mechanisms for evaluating client contacts or outcomes, understanding the differences in caseloads, or making adjustments to ensure that caseloads are balanced and appropriate.

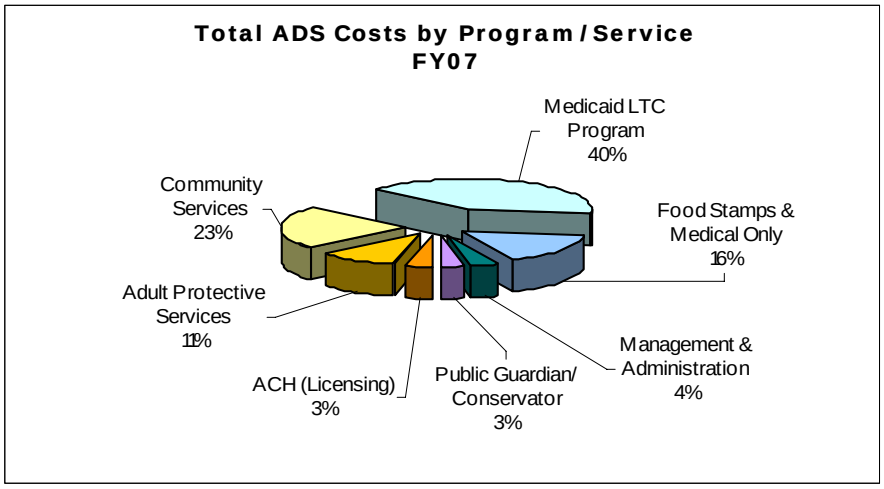
Audit recommendations are focused primarily on problems with the reliability and use of data in management decisions. In particular, we recommend that ADS work with the state to solve discrepancies in statistical reports. We recommend that ADS work with the county's Information Technology Division to develop an online monthly reporting system and guidelines for more consistent reporting. We also recommend that ADS consider expanding the capacity to serve the growing number of minority clients and those with limited English proficiency. Finally, ADS should work with the state to ensure that there is an infrastructure to support home care workers and to prepare for future demand for their services.

Over the course of this audit, we had the opportunity to meet with case managers and other staff and observe them as they carried out their work. Doing so provided us with tremendous insight about the issues they face in meeting Program responsibilities and service goals. Case managers also assisted us in developing the nine brief client profiles that can be found throughout the "Audit Results: Community Continuum of Care Options" section of the report. We saw it as valuable to place these profiles in the context of our analyses. Not only because doing so brings greater awareness of the real people receiving Program services and the equally real challenges facing ADS staff and managers, but because it enriches our analyses.

Background

The mission of the Aging & Disabilities Services (ADS) Division is to enable older adults and people with physical disabilities to live as independently as possible. ADS provides a range of services in the community to meet the diverse needs and preferences of their clients. ADS service units include the following: the Medicaid Long-term Care (LTC) Program; Community Services; Adult Protective Services; Adult Care Home Program (ACHP) licensing; and the Public Guardian/Conservator Program. ADS also assists senior and disabled clients who are only eligible for food stamps and medical programs with accessing community resources. Exhibit 1 shows the percentage of total ADS costs by program area, as well as costs assigned to management and administration.

Exhibit 1

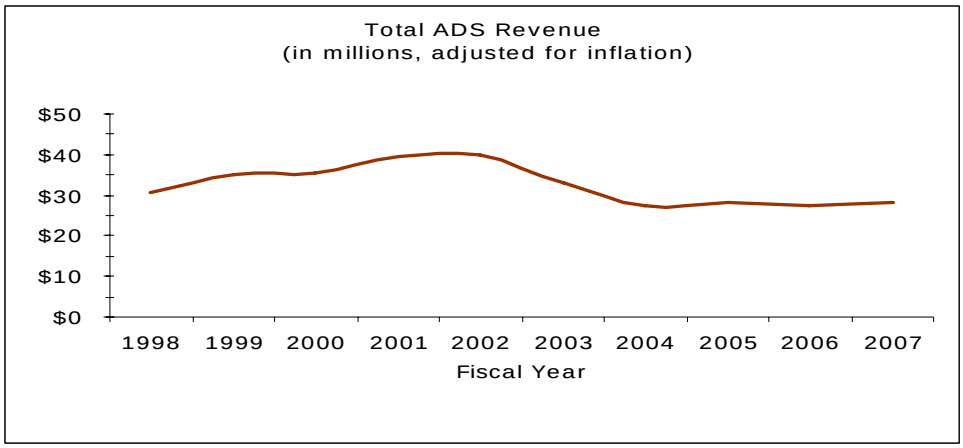


Source: Auditor's analysis of county financial reports

Our audit of ADS focused on the Medicaid LTC Program which authorizes federal Medicaid spending for long-term care alternatives to nursing home placement. For more than 25 years, Oregon's nationally recognized approach to Medicaid long-term care services has allowed seniors and people with disabilities to live primarily in their homes and community-based facilities rather than in institutions, such as nursing facilities.

Exhibit 2 shows actual revenues for ADS over the past ten years, a period that includes significant funding and service level changes in the Medicaid LTC Program. The initial cuts that occurred during FY03 and FY04 eliminated Program services to clients requiring the least amount of assistance. Some of the services affected by these cuts were temporarily restored or replaced by other programs funded in part by the county's temporary personal income tax (ITAX), which was in effect from FY04 through FY06.

Exhibit 2



Source: Auditor's analysis of county financial reports

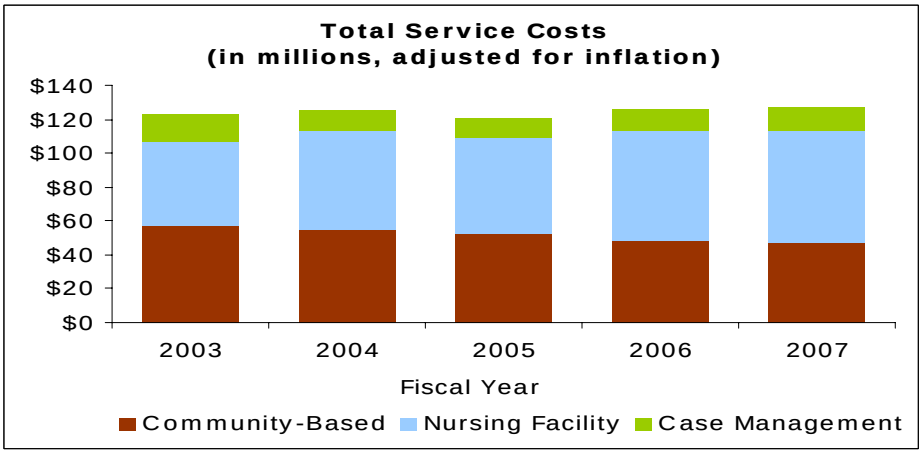
Medicaid LTC Program Overview

In Multnomah County, the Medicaid LTC Program provides case management to link clients with services. During Fiscal Year 2007 (FY07), the Program served a total of 7,023 unduplicated clients. Clients served are very low-income seniors age 65 and older and adults with disabilities who meet Medicaid guidelines for nursing home placement. ADS provided long-term care case management services for seniors through an intergovernmental agreement with the State of Oregon since 1986 and began serving people with physical disabilities in 1998.

Medicaid LTC Program case management is provided by 144 employees who work out of five branch office locations throughout the community. Most of these offices are co-located with senior centers where other ADS services are available to all seniors in the county. Most costs for case management are reimbursed by the state, primarily from federal Medicaid dollars. County General Fund monies provide local match dollars (Medicaid reimburses about $2 for every $1 of General Fund match). In FY07, the local match was approximately $1.8 million.

Exhibit 3 shows the total service costs for Medicaid LTC Program clients. Nursing facility and community alternative costs are directly incurred by the state. Total service costs for Program clients were $127 million in FY07, including $14 million for case management.

Exhibit 3



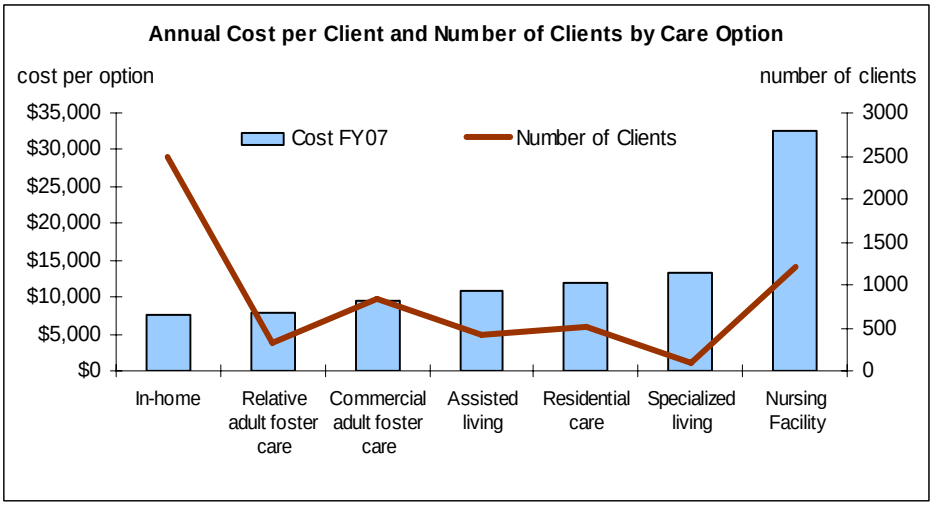
Source: Auditor's analysis of state claims data and estimated case management costs

Medicaid waiver services

Oregon received a "waiver" from federal Medicaid long-term care program requirements that allows clients to be placed in settings other than nursing facilities. Care alternatives under the state's Medicaid waiver include in-home care, adult foster care (both commercial and relative), assisted living facilities, residential care facilities, and specialized living facilities. Most of these facilities are licensed to accept both Medicaid and private-pay clients. Other services include home-delivered meals, adult day care services, and non-medical transportation.

Overall, about 42% of all ADS long-term care clients (including those in nursing facilities) receive in-home services. About 37% are served in community-based facilities, and only 21% are served in nursing facilities. Using information from county and state records, we were able to calculate the average cost per client receiving care in community alternatives compared to those in nursing homes. The following chart compares client numbers and costs for long-term care in FY07 for each of the long-term care alternatives.

Exhibit 4



Source: Auditor's analysis of Oregon ACCESS data and state claims data

Medicaid LTC case managers link each client with services based on the amount of assistance needed, their individual choices and preferences, and whether help may be available from family, friends, or neighbors. The state requires case managers to perform a number of functions:

- determine financial and service eligibility within 45 days of initial client contact;
- assess individual care needs and develop a plan of care at least annually, or as needs change;
- implement the plan ensuring the least restrictive, most cost effective placement;
- authorize services to be provided;
- authorize payment and compute applicable client contributions;
- provide ongoing monitoring and assistance to the client as needed or requested; and
- maintain documentation that supports the service eligibility decision.

Program qualification requirements: client needs, income, and age

- Client needs – Needs are defined by a set of "activities for daily living" (***ADLs)*** which are categorized into a set of "service priority levels" (***SPLs)***. These establish initial eligibility and help case managers identify the type of care and services an individual needs. Half of Medicaid LTC clients in service in June 2007 were classified in the highest need category and required full assistance for most ***ADLs***. About 41% required substantial assistance in one or more of the ***ADLs***, and only 9% require minimal assistance. Exhibit 5 explains the categories of ***SPLs*** and the ***ADLs*** that define the various categories.

Exhibit 5

	SERVICE PRIORITY LEVEL	Description of Client Impairment and Need
Full Assistance	Level 1	Full assistance in all major activities of daily living. Requires hands-on care throughout the day.
	Level 2	Full assistance in mobility, eating and cognition. Does not require help with toileting.
	Level 3	Full assistance in at least one of the following: mobility, eating, or cognition.
	Level 4	Full assistance in toileting.
Substantial Assistance	Level 5	Substantial assistance with mobility and eating. Some assistance with toileting.
	Level 6	Substantial assistance with mobility and eating.
	Level 7	Substantial assistance with mobility and some assistance with toileting.
	Level 8	Some assistance with mobility, eating, and toileting.
	Level 10	Substantial assistance with mobility.
Minimal Assistance	Level 9	Some assistance with eating and toileting.
	Level 11	Some assistance with toileting and ambulation.
	Level 12	Some assistance with eating and ambulation.
	Level 13	Some assistance with toileting.

Source: State of Oregon, Department of Human Services, Seniors and People with Disabilities Division

Note: Service priority levels 14 though 17 were discontinued by the state in 2003.

- Income and resources – According to the state's "Client Data Book," 54% receive Supplemental Security Income (SSI), which is $624 per month. The remaining clients have incomes over this amount (but under $1870 per month). Those with incomes over the SSI amount are required to pay for some of their care, based on their ability to pay.
- Client ages – To qualify for the Program, an individual must be a senior age 65 and over or an adult with disabilities under the age of 65. About two-thirds of Program clients are seniors, and one-third are people with disabilities under the age of 65. There are some

significant differences between the seniors and the younger disabled population served by the Program.

- While women make up 70% of the seniors, they are 54% of the younger disabled population.
- Those of Asian descent make up 3% of the younger disabled clients, but are 11% of the senior population.
- African Americans make up 14% of the younger disabled population, but are 8% of the senior population.
- A much larger percentage of clients with disabilities (93%) are English speakers, compared to 75% of the senior clients.
- The service priority level profiles of these two sub populations are very similar.

Scope and Methodology

The objectives of this audit were: a) to provide Program managers, the public, and the Board of County Commissioners with a descriptive profile of clients, costs, and services; and b) to determine whether the Program is equipped to meet the increasing demand for these services in the future.

Our audit scope was limited to the Medicaid Long-term Care (LTC) Program administered by the Aging & Disability Services (ADS) Division. The Program provides on-going case management and long-term care services to clients who met both the financial and functional criteria for nursing home placement under Oregon's Medicaid waiver for long-term care. Although Medicaid clients placed in nursing homes are not technically served under the waiver, we included them to get a comparative perspective on costs and services. Because of data limitations, we were not able to include in our scope clients not eligible for case management services under the Medicaid waiver but who received "State Personal Care" services, or those case managed through Oregon Project Independence. The audit also excluded clients eligible only for medical services and food stamps under Medicaid.

Our analysis of Medicaid LTC Program clients, services, and costs was based on five years of data obtained from both the state and the county. See Appendix A for the detailed methodology. We also interviewed Program staff including managers, supervisors, case managers, and office and case management assistants who provided us with information about their clients, issues, and problems. They assisted with the development of a sample of individual client profiles.

We assessed the Program based on its stated goals and good public management principles. Program goals and criteria for the audit were identified in our review of county, state, and federal laws, rules, contracts, policies, and procedures. We also reviewed reports, research studies, and performance audits, and we have included a selected bibliography in Appendix B.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Audit Results: Review of Quantitative Data

We worked with both the state and the Aging & Disabilities Services (ADS) Division to obtain five years of data and information for the Medicaid Long-term Care (LTC) Program. Using available data, we analyzed a number of service and demographic trends. We identified the following areas for improvement: increasing the reliability and use of data; improving caseload counts; balancing caseloads; and using data to plan for service needs.

Increase Reliability and Use of Data

Better information could guide the deployment of resources

We calculated a total of 15,264 unduplicated clients served by the county's Medicaid LTC Program between July 1, 2002 and June 30, 2007. About 4,400 were served for more than three years (30%), and about 1,800 were served continuously for all five years (12%). These statistics suggest a relatively stable service population. Further, clients very rarely transferred to a different branch for case management, with about 80% of clients over the five-year period being served at the same branch.

These data are relevant to the management of the Medicaid LTC Program and deployment of resources. For example, some important trends emerged from our analysis of a snapshot of clients receiving service on June 30, 2007. Looking retrospectively at five years of services in the Program, we found the following:

- Clients managed out of the West and North/Northeast (N/NE) Branches spent a higher percentage of Program months receiving in-home care, the least costly and least restrictive of settings.
- Females spent slightly more time in their homes, while males were slightly more likely to be placed in a nursing facility.
- English-speaking clients spent 26% of Program service months in nursing homes, while nursing home percentages were much lower for all other non-English speaking groups. Eastern European-language speakers spent the highest percentage of time in an in-home placement.
- Because seniors were less likely than the disabled to stay in their homes, the total five-year cost for seniors was higher on average.
- Clients who were married or separated had the highest in-home care rates, while those who were not married were more likely to be placed in a nursing home, resulting in higher monthly costs.

Data often not available, consistent, or reliable

Some important information was not available, or we found it to be inconsistent, unreliable, or difficult to extract from state data systems. ADS must rely on the regular management reports generated by the systems the state uses to maintain client and claims data. These mainframe-based systems were originally developed in the 1970s, and the reports they generate are not well documented or understood. ADS management also indicated that these systems were designed to facilitate reporting to the federal government, not as tools to manage programs more effectively.

ADS has initiated efforts to address data quality, but with limited success. Additional management data on clients and their needs are available through monthly client files extracted from Oregon ACCESS – the system used to determine eligibility and develop case plans. Also, since 2003, the county's Information Technology (IT) Division has worked with ADS to create a

range of monthly reports that can be generated by management or line staff. While these reports provide ADS the flexibility to create their own management information, critical data regarding client disabilities and mental health issues are maintained in narrative form only, restricting the level of analysis staff can perform.

ADS has recognized the limitations of current data systems and has initiated a series of planning efforts to develop solutions. While some important improvements have been achieved through these efforts, including the development of well-documented and detailed monthly reports, we found a number of inconsistencies and reliability problems. Also, ADS continues to be unable to identify critical client needs, analyze data on clients in conjunction with service and cost data, or generate basic unduplicated annual counts of clients served due to its reliance on state data systems.

As ADS and the state look to find ways to provide services to an increasing number of seniors and persons with disabilities, we recommend that they make it a priority to develop more streamlined information systems that provide the county with better data to manage clients and services and plan effectively for the future.

Data not available to describe client need

We asked both county IT staff and state analysts to provide us with data on clients' disabilities, as well as their physical diagnoses and mental health needs. We found that while Program case managers may record some of this information in the narrative sections of the Oregon ACCESS system, such data cannot be extracted for management analysis.

One example of missing information which is essential for management and planning is data on client mental health issues. Many case managers reported increasing numbers of clients with mental health and behavioral problems, and indicated that these clients are the most labor intensive. These issues are also discussed in state and national reports. For example, national census-based estimates indicate that about 62% of the current disabled population suffers from physical disabilities, and about 39% suffer from mental disabilities. However, ADS was not able to provide us with data on specific client disabilities in its service population.

Client tracking needs improvement

Neither the state nor ADS has the capacity to examine the ways in which clients age in the Medicaid LTC Program, since data systems are not designed to track clients. We were able to merge our data on claims over a five-year period with client snapshot files to provide a unique analysis of clients' experiences in the Program over time.

Our analysis shows that younger disabled clients have seen increases in nursing home placement rates over time. Despite a 15% decline in the total number of disabled clients served since FY03, the number of younger disabled clients in nursing facilities increased from 309 in June of 2003 to 344 in June of 2007. Increased movement of a few clients to nursing homes from care settings that allow for greater independence has the potential to raise Medicaid LTC Program costs very quickly. However, we found that data were not available to document client movement, including the extent to which clients move in and out various Program services.

We found that 29% of the clients served over the five-year period spent all of the months served in the Medicaid LTC Program receiving in-home care. This finding suggests that there is stability in long-term placements and that services may be working reasonably well, since the typical client, once placed at home, is likely to remain in that setting. However, another 27% of the

clients served spent all of the months in service in a nursing facility. This suggests that ADS is doing less well at transitioning clients out of nursing homes, once they are placed there.

We identified 2,408 Medicaid LTC Program clients who were receiving services in both July of 2002 and June of 2007, or16% of the total served over the five-year period. Exhibit 6 compares their care placements at the beginning and end of the five-year period. For example, we found that 84% of the clients living in their own homes in 2002 and still receiving services in 2007 had remained in that placement. About 12% had been transferred to a community-based facility and about 5% had been transferred to a nursing facility. About 84% of the clients placed in foster homes in 2002 and still receiving services in 2007 were still in that placement, and only 5% had been transferred to nursing facilities.

Exhibit 6

2007 Placements as % of 2002 Placements	Clients 2002	In-Home 2007	Foster Home 2007	Assisted Living 2007	Residential Care 2007	Specialized Living 2007	Nursing Home 2007
In-home Care 2002	1,419	84%	8%	2%	1%	1%	5%
Adult Foster Home 2002	424	6%	84%	1%	3%	1%	5%
Assisted Living 2002	93	4%	6%	62%	5%	1%	20%
Residential Care 2002	133	3%	13%	4%	60%	1%	20%
Specialized Living 2002	61	13%	8%	3%	3%	67%	5%
Nursing Home 2002	278	3%	3%	1%	2%	0%	91%

Source: Auditor's analysis of state claims data – placements based on last claim for each month

The remaining community-based facilities statistics in Figure 6 above show somewhat less client continuity. About 20% of those in residential care and assisted living facilities in 2002 had been transferred to nursing facilities by June of 2007. About 13% of those in specialized living facilities in 2002 were placed at home in 2007.

Nursing facility placements are the most stable of all, suggesting again that transitioning clients from nursing facilities once placed there is difficult. Only 3% of those in nursing homes in 2002 were placed at home in 2007. About 6% were transferred to community-based facilities.

Staffing for data and research was limited

Because of staff turnover in recent years and pressure to preserve limited resources for client services, ADS did not fully staff its data and research function. During our audit, one analyst was primarily responsible for preparation of the annual Local Area on Aging Plan, and another newly hired analyst spent limited time on Medicaid LTC Program caseload reports. The Division had funds in its budget to support an additional senior research analyst, but that position was not filled until after the audit was completed. We are hopeful that the weaknesses we identified around using data more effectively will now be addressed through the hiring of a research analyst specifically dedicated to the Program.

Improve Caseload Counts

Funding is based on state caseload standards

The state allocates funding for case management staff and associated costs to ADS for the Medicaid LTC Program using a formula based on client counts and state caseload standards. State caseload standards vary by type of client placement with the lowest caseloads for in-home and foster care clients, followed by clients in community-based facilities, and higher caseloads for those in nursing homes.

Some counties in Oregon have the intake and ongoing case management functions handled by the same staff. However, ADS uses a higher level position to conduct intake, do initial case planning, and provide comprehensive assessment and core planning. Intake workers in the Medicaid LTC Program are expected to complete 15 intakes per month. This allows ongoing case managers to focus primarily on the necessary case management tasks that are performed after clients have been placed and stabilized. As a result, ADS maintains higher caseload standards than the state for its ongoing case managers. These higher caseload standards have also allowed ADS to "carve out" service intake and screening positions that are not specifically funded by the state.

Exhibit 7

Caseload Standards by Type of Client Placement (# of clients per case manager)	State Standard	ADS Standard
In-Home	66	86
Adult Foster Care	76	99
Specialized Living Facility	69	125
Residential Care Facility	96	125
Assisted Living Facility	98	125
Providence Elder Place	100	100
State Personal Care	69	95
Nursing Facility	120	163

Source: ADS Program Information

Historically, the state has not fully funded counties providing Medicaid long-term care services. In 2003 for example, ADS received 82% of state estimated Program costs based on state personnel costs. ADS managers have long argued that this method of funding represents an "equity gap" that is more pronounced in Multnomah County, where the costs of personnel, facilities, and overhead (such as IT support) are generally higher than they are in other counties.

Beginning in July of 2007, ADS began receiving 90% of estimated state long-term care costs, and with its General Fund match, expects to be closer to being fully funded. Exhibit 8 illustrates that these changes have effectively increased the revenues for case management on a per client basis and reduced the ratio of clients served to case management staff. State Personal Care Program clients were not included in the client count, but the number of full-time equivalent employees (FTE) and costs allocated to that small program are included. As a result, costs per client may be slightly overstated.

Exhibit 8

Medicaid LTC Program Funding and Caseload Trends	FY03	FY04	FY05	FY06	FY07	5-Year % Change
Estimated Case Management Costs (in millions)	$16.1	$11.4	$12.0	$12.9	$14.0	-15%
Budgeted Case Management FTE	106	86	91	89	90	-17%
Annual Unduplicated Clients Served	9,350	8,005	7,746	7,261	7,023	-33%
Total Case Management Cost per Client	$1,724	$1,423	$1,550	$1,775	$1,991	13%
Unduplicated Clients per Budgeted Case Management FTE	88	93	85	82	78	-14%

Source: Case management costs estimated by Auditors based on ADS estimates of FTEs allocated to the Medicaid LTC Program. Unduplicated client counts based on Auditor's analysis of state claims data. All costs adjusted for inflation.

Errors in state reports result in inaccuracies in caseload counts

In the course of our audit work, we found that the caseload counts used by ADS to justify staffing levels have been inflated by errors in state reports. The state reports effectively double-count clients receiving state Personal Care Program services. These clients are not technically eligible for the Medicaid LTC Program, but are included in the counts of in-home clients. As of June 30, 2007, there were about 376 state Personal Care Program clients also case managed by ADS. Some of this error may be offset by the fact that some clients placed in specialized living facilities and case managed by the Medicaid LTC Program are not included in the state's report. As of June 30, 2007, there were about 67 such clients. ADS should work with the state to determine an appropriate solution to address these discrepancies.

Balance Caseloads

Better use of data may help manage caseloads

We found significant differences in the demographics of Medicaid LTC Program clients case managed out of the five branch offices. The West Branch case managed the highest percentage of younger disabled clients (42% of the branch caseload), but had a lower percentage of senior clients, especially seniors 85 years of age and older. The North/Northeast (N/NE) Branch case managed the highest percentage of minority clients (48%), but the lowest percentage of those with limited English proficiency (10%). The East Branch case managed the lowest percentage of minority clients (14%) and Mid County Branch case managed the highest percentage of those with limited English proficiency (32%), with high numbers of clients of Asian and Eastern European heritage. The East Branch case managed the highest percentage of high need clients (50%), while the West (34%) and N/NE (30%) Branches case managed relatively fewer high need clients.

Branch differences – including the Nursing Facility Branch which handles only clients placed in nursing facilities – are summarized in Exhibit 9:

Exhibit 9

Client Characteristic June 30, 2007	SE Branch	West Branch	N/NE Branch	Mid County Branch	East Branch	Nursing Facility Branch
Disabled <65	33%	42%	36%	30%	36%	28%
Seniors 65+	67%	58%	64%	70%	64%	72%
Seniors 85+	21%	15%	19%	19%	20%	30%
Minority Clients	21%	21%	48%	15%	24%	14%
Limited English Proficient	21%	25%	10%	32%	18%	5%
Full Assistance Required*	44%	34%	30%	44%	50%	79%

Source: Auditor's Office analysis of Oregon ACCESS extract files

Improved data would help balance caseload assignments

ADS does not have an automated or consistent system for assigning new cases to case managers to ensure that workloads are equitably distributed across staff within branches or across branches. We found that systems for allocating cases are loose, not documented, and vary by branch office. Although ADS has plans to move to facility-based caseloads in all branches, the plan has not been implemented system-wide. The Branch Monthly Activity Reporting (BMAR) system allows branch managers to track the caseloads of individual staff members based on ADS standards, but we found that only the Mid County, N/NE, and West Branches use this tool to manage caseloads. Based on all these conditions, we expected to see caseload imbalances reflected in our data analysis.

When we adjusted caseloads to take into account ADS' caseload standards, we found that as of June 2007, Program caseloads in all branches except the Nursing Facility Branch were at about 81% of ADS' caseload standard. Consistent with the results in Exhibit 8 but using a different methodology, we found that actual caseloads for ongoing case managers had decreased from a high of 98 clients per case manager in June of 2003 to about 87 clients per case manager in June of 2007. Some of these reductions may be offset by shifts in clients no longer eligible for Medicaid LTC Program services to state Personal Care Program services.

We found that caseloads varied both within and across branches. Because the Medicaid LTC Program does not evaluate client contacts or outcomes, we were unable to assess whether branches with relatively higher caseloads – such as the Mid County and East Branches – were more efficient and productive or whether case managers in those branches were spending less time with clients. Management indicated that managers review caseload staffing reports quarterly.

Exhibit 10

Actual Caseloads as a % of ADS Standards: June 30, 2007	
Southeast Branch	78%
West Branch	75%
N/NE Branch	74%
Mid County Branch	83%
East Branch	87%
Sub Total for Above Branches	81%
Nursing Facility Branch	103%
Total	**83%**

Source: Auditor's analysis of Oregon ACCESS files and payroll data

Consistent reporting guidelines are needed if data are to be useful

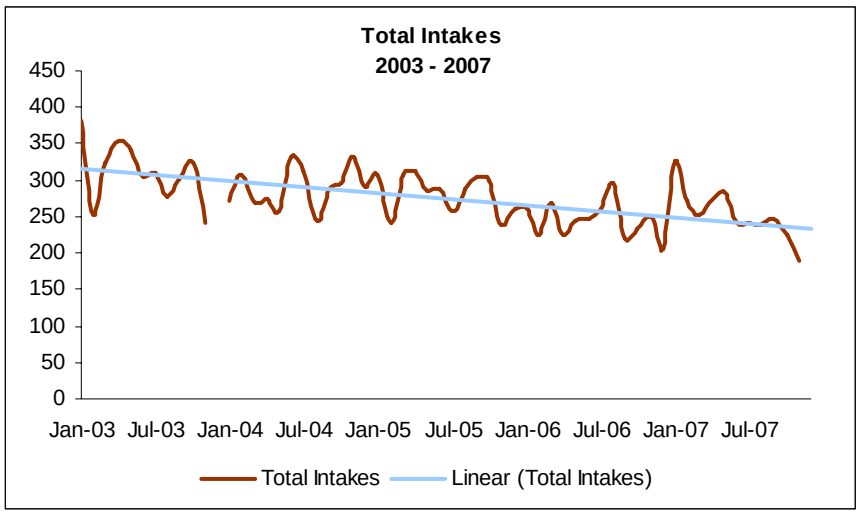
ADS has a potentially useful source of management data on its LTC Program in the BMAR system. On a monthly basis, each branch reports the number of new and pending referrals for service, as well as referral dispositions. However, we found that recording of these activities is inconsistent among branches, with some branches submitting manual counts, while others use electronic reports.

We recommend that ADS develop an online reporting system for branches to use to report monthly activities, as well as develop guidelines so that data are more consistently reported. We also recommend that ADS management require that all branches use consistent methodology to track workload through the BMAR system. Once data are more reliably and consistently reported, they can be used to better assign and monitor client caseloads.

BMAR system could be used to analyze intake process

We found that ADS could better utilize BMAR system data to monitor the efficiency and effectiveness of its intake processes. Medicaid LTC caseloads are driven primarily by initial determinations about who is eligible for services. Most clients, once eligible, receive services for many years and often until their deaths. With fewer seniors eligible for services over the five years reviewed, ADS saw steady declines in monthly intakes.

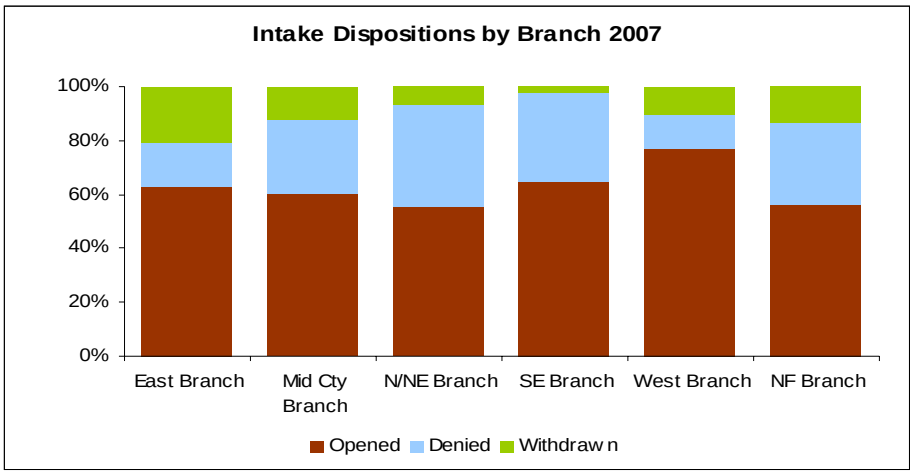
Exhibit 11



Source: Auditor's analysis of BMAR system data

We found that intake dispositions varied from branch to branch, perhaps reflecting differences between the various branches. The N/NE Branch had the highest denial rate and was also the branch with the lowest caseloads. The West Branch opened the highest percentage of new cases, likely because many of its new intakes involved younger disabled clients who were "presumptively eligible" for Medicaid LTC services because of their physical disabilities.

Exhibit 12



Source: Auditor's analysis of BMAR system data

ADS complies with intake and annual assessment requirements

ADS is required to complete eligibility determination within 45 days of client intake, although state rules allow exceptions when more time is needed due to client circumstances. BMAR system data on compliance with this timeline was available beginning in FY2005. We found that ADS' intake case managers improved in their compliance with this standard. In FY05, 26% of the pending intakes were more than 45 days old, compared to 18% in FY07.

ADS case managers are also required to complete annual assessments on all Medicaid long-term care clients. The state's Medicaid payment system is designed to withhold payments to care providers if these assessments are not completed on a timely basis. Our analysis of Oregon ACCESS data indicated that ADS staff members were completing assessments as required. In the four years for which data were available, we identified a very small percentage of cases (1-2%) in which more than 12 months elapsed between assessments.

Using Data to Plan for Service Needs

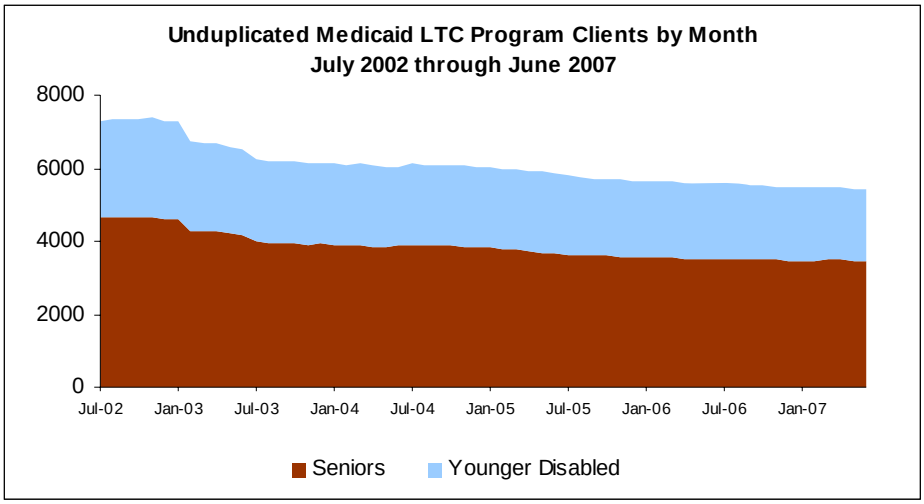
Planning effectively for the future requires good information on clients, services, and costs. It also requires a solid understanding of past and present trends which are driven by client demographics and federal and state policies. We reviewed recent trends in the number of clients and types of services, as well as short and long-term demographic projections for Multnomah County. We found that ADS does not have adequate information to plan for and manage future changes.

Five years of service reductions following changes in eligibility

Up until early 2003, the Medicaid LTC Program served anyone with "service priority levels" (***SPLs***) from 1 through 17 – refer to Exhibit 5, page 8. Due to budget cuts in 2003, the state terminated long-term care services for those with ***SPLs*** from 12 to 17. Effective July 2004, services were restored for clients with ***SPLs*** of 12 and 13. Since these changes were enacted, clients needing limited assistance in eating, ambulation (moving from place to place), or bathing/dressing have not been eligible for Program services. In addition, the state also tightened up the definitions and criteria used to determine eligibility.

The impact of these changes in the eligibility criteria is illustrated in Exhibit 13, with sharp declines from July 2002 to July 2003. During initial implementation of the new policies in FY03, about 1,100 clients with relatively lower-level needs were terminated from services and the total Program caseload dropped from about 7,300 to 6,200.

Exhibit 13



Source: Auditor analysis of state claims data

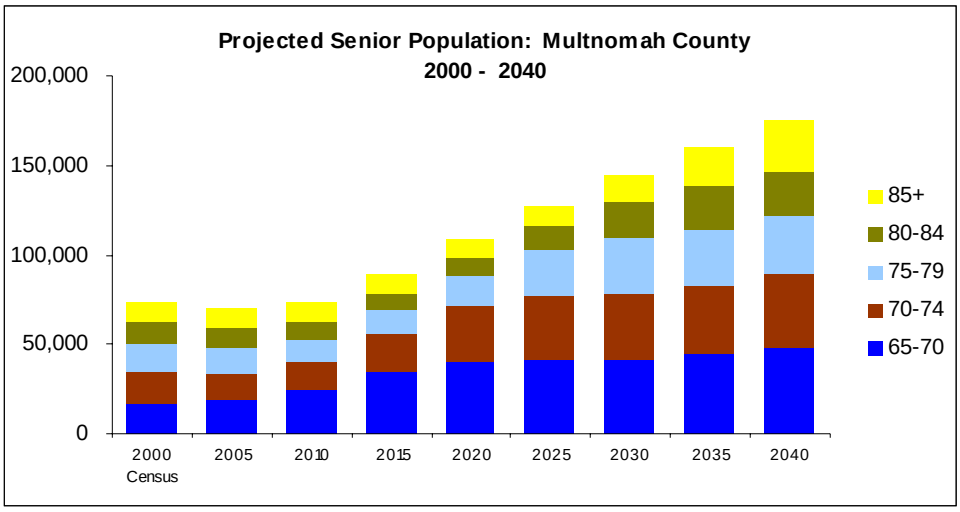
Caseloads continued to decline among senior and disabled populations equally, although ADS management indicated that there was a significant increase in the level of acuity and client need. Our analyses of available data showed there were very few changes in the types of clients served or the mix of care placements since the policy change was implemented. However, a larger portion of clients now served by the Medicaid LTC Program require higher levels of care.

Management challenge: planning for future increases in demand

In 2006, the Governor's Commission on Senior Services issued a report on the future of long-term care in Oregon. The report called attention to the approaching "demographic tidal wave" which is expected to nearly double the population of seniors over the age of 65 by the year 2030, both nationally and in Oregon. The report also concluded that as the population ages, "the burgeoning number of seniors and people with disabilities needing long term care could easily overwhelm Oregon's capacity to pay for needed services as currently structured." County ADS managers are working with state partners on a long-term planning effort. However, in the short term, the state projects that ongoing declines in the long-term care caseloads are expected to continue at least through the end of the FY11.

We analyzed available demographic projections for Multnomah County produced by the Oregon Office of Economic Analysis to better understand what the future may hold for the county's Medicaid LTC Program. As Exhibit 14 shows, the demographic wave of seniors is not projected to hit Multnomah County until 2015. Census data indicate that about 12% of Oregon's population aged 16 - 64 has a disability. Given that prevalence, we estimate that only about 3% of the county's disabled adults currently receive long-term care services through ADS programs. For clarification, it should be noted that additional clients under 65 with developmental disabilities or mental health diagnoses are case managed by other county programs.

Exhibit 14

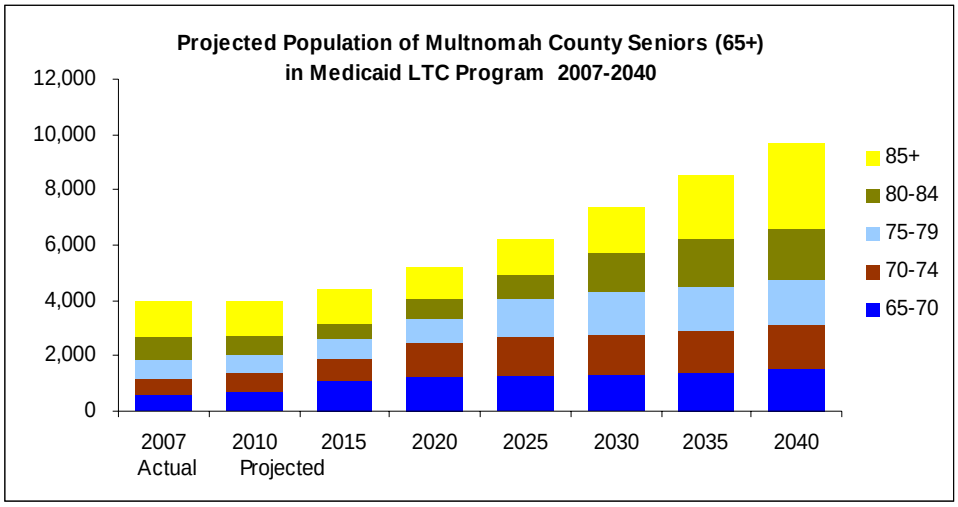


Source: Auditor's analysis of projections from the Oregon Office of Economic Analysis

Projections do not include people age 18 – 64 with disabilities

Exhibit 15 indicates how these demographic increases would play out if the existing demand-for-service rates hold. For example, currently about 6% of the seniors 65 and older in Multnomah County are served in the Medicaid LTC Program. The service rate for the youngest seniors (65-69 years old) is about 3%, compared to 11% for those 85 and older. What is most notable is that in the short term, the greatest increases will occur among the youngest seniors who are most likely to remain in their homes while receiving long-term care services. Thus the immediate issue will be to ensure that the infrastructure supporting the home care workers caring for ADS clients is adequate given the increased demands for their services in the near future. Growth in the oldest group of seniors (85+) who are most likely to require more expensive nursing home care is not projected to occur until after 2025.

Exhibit 15



Source: Auditor's analysis of projections from the Oregon Office of Economic Analysis

Projections do not include adults age 18 – 64 with disabilities

Audit Results: Community Continuum of Care Options

The community continuum of care alternatives for seniors and people with disabilities allows for individual choice and preference and provides for their health and safety. Case managers link clients to these alternatives to nursing home care and other community resources, particularly when clients lack the assistance of friends and family.

We interviewed 26 case managers to get a better perspective on the issues facing them and their clients. Case managers confirmed that client caseload size has decreased over the last few years but felt administrative time had increased, restricting their ability to spend time with clients. They also raised concerns about the health and well-being of those who do not qualify for the Medicaid LTC Program, but continue to have unmet needs. Some case managers indicated that preventive care services, which currently are not available, would save dollars and improve the quality of lives in the long run.

While they generally like using the Oregon ACCESS data system, case managers reinforced our finding that current data systems need streamlining and improvements. They indicated they spend more time than necessary and often enter the same data in many different fields, screens, and reports. Some complained that the state's computer systems are antiquated and that they have to enter the same information into three different systems.

Case managers highlighted additional issues that were also identified in numerous state and federal reports. These include the increasing need for housing and mental health services for this population, concerns about the numbers and quality of home care workers, and cultural/language needs for the diverse and changing population. Some case managers also mentioned the need for more training, especially for handling clients suffering with mental health and behavioral problems.

In addition to the demographic data we reviewed, case managers provided us with case profiles of a few individual clients. These case profiles bring a human face to some important client issues that are not currently tracked by management in the long-term care data systems. The profiles, presented throughout the discussion of care settings that follows, are meant to be illustrative and may not be representative or typical of the clients in each setting.

In-home Care

In-home care services allow clients to live in their own homes with the support of home care workers who assist clients with "activities of daily living" (***ADLs***). This option is generally the least expensive and allows the client the most independence. In FY07, 42% of Program clients received in-home care.

Four categories of home care worker assistance is available, depending on a given client's needs and preferences. Home care workers can be independent and paid on an hourly basis, or in some cases, they can be hired through an agency. For those clients who require more intensive services, live-in care can be authorized. Finally, a client living with a spouse who is able to provide needed assistance can be authorized to have his or her spouse paid to serve as the home care worker.

J. is in his early 40s and receives in-home dialysis administered by his wife, who is paid under the Oregon Medicaid waiver as a spousal caregiver. He has very complicated medical and psychological problems including diabetes, end-stage renal failure, and hypertension, among other conditions.

J. is a father of young children, and he is very frustrated that he requires complete care for all of his health needs and cannot work to support his family. He would not likely thrive emotionally or physically in another care setting because his entire life is centered on his family.

Medicaid LTC Program case managers authorize the type of home care provider and the maximum number of hours that can be provided. They also approve home care workers' timesheets. Although clients are technically the employers and hire and fire their own home care workers, case managers often must assist clients in finding or replacing home care workers. Case managers indicated that managing issues related to home care workers was akin to having a second caseload.

In 2003, home care workers were unionized under a bargaining contract with the Service Employees International Union (SEIU) which increased wages and provided benefits. Home care workers are registered through the state. Although home care workers must pass a criminal history background check and complete a mandatory half-day orientation, there are no other professional or training requirements, or ongoing licensing or inspections to ensure quality of care.

The Oregon Homecare Commission provides a range of ongoing training opportunities for home care workers who are interested in pursuing them. The Commission has recently developed an online home care worker registry that provides information about a care worker's availability, skills, and training, in addition to the type of clients he or she works with. The registry is also a resource for home care workers seeking employment.

Younger and non-English speakers most likely to be placed at home

As of June 30, 2007 there were about 2,500 Medicaid LTC Program clients receiving in-home care in Multnomah County. Of these, the large majority (60%) lived in an apartment; only about 40% lived in a single-family home. A higher percentage of disabled clients received in-home services (55%) compared to seniors (35%), with about 32% of the disabled clients receiving these services in apartments. The West Branch office had the highest percentage of clients receiving in-home care (66%), and the East Branch had the lowest (43%).

Minority clients had higher in-home placement rates (55%), compared to Caucasian clients (39%). Even more striking were in-home placement rates by language. Among those with limited English proficiency, 65% received in-home care, compared to 36% for English speaking clients. While these differences may reflect client choices, they underscore the need to explore whether there are enough culturally competent facilities for minority and non-English speaking clients, particularly in the areas of the county where those populations tend to live.

In-home placement was significantly correlated with age, with younger clients more likely to be supported at home. For example, 57% of clients under 65 years of age were placed at home, compared to 19% of clients 85 years of age and older. The correlation between ***SPLs*** and in-home placement was much less linear. While higher-need clients requiring full assistance with multiple activities (***SPLs*** of 1-4) were the least likely to be supported at home (22%), those requiring substantial assistance were actually more likely to be placed at home (65%) than those requiring minimal assistance (51%).

M. is 75, lives on Supplemental Security Income (SSI) of about $600 per month and has been in the Medicaid LTC Program for over 13 years. She has been diagnosed with fibromyalgia and back problems. She has not been given a mental health diagnosis, but her case manager reports she is an "obsessive hoarder." She refuses to see a doctor and takes no medications. She has family, but will not provide names or phone numbers to her case manager.

M. lives in unsanitary conditions in a large subsidized apartment complex and is homebound. She collects clothing out of dumpsters and stacks items around her home. M's smoking is hazardous given the clutter of her home.

M. needs assistance remembering events, maintaining awareness, and using good judgment. She can be threatening to others, and recently her home care worker of many years resigned because M. was verbally abusive. Her case manager has been assisting with finding a new home care worker who is suitable and willing to work with M.

Cost of in-home care

Exhibit 16 summarizes annual services and costs for clients receiving in-home care as of June 30, 2007. The average total annual cost for in-home care (including all services) was about $7,600 per client. About 85% of the clients who received in-home care were assisted by an independent home care worker, for an average of 19 hours per week. Only 8% were provided with a live-in caregiver, and those with the highest need (***SPLs*** of 1-4) were most likely to be authorized for live-in care services.

Very few clients placed at home (1%) received care from a paid spouse. Over half of these were cases managed at the East Branch. On average, spouses were paid for 59 hours of care per week. A few clients were also authorized for adult day care, with more than half of these managed by the West Branch. Overall, 11% of the clients with in-home placements received home-delivered meals and 12% were reimbursed for mileage associated with non-medical transportation.

Exhibit 16

Annual Service Profile for In-home Clients (FY07)	Number of Clients	% of Total In-home Clients	Average Annual Cost
Total # of In-home Clients	2,489	100%	$7,640
By type of in-home care:			
Home Care Hourly	2,108	85%	$6,608
Home Care Agency	107	4%	$1,800
Home Care Live-In	210	8%	$12,447
Spousal Pay	28	1%	$13,890
Other in-home services:			
Adult Day Care	32	1%	$4,270
Home Delivered Meals	266	11%	$1,780
Non-Medical Transport	296	12%	$118

Source: Auditor analysis of Oregon ACCESS data, state claims data, and estimated case management costs

Adult Foster Care Homes

Adult foster care homes are private homes with 24-hour care in a home-like setting for up to five people. Meals are provided and sleeping rooms and bathrooms may be private or shared. Relative foster care homes can be authorized with family members paid to provide care.

> *S. has been in the Medicaid LTC Program for ten years, and he is now 38 years old. He has been placed in relative foster care with his mother and stepfather. He has a brain injury from a drug overdose, and he has no short-term memory or impulse control and needs full assistance with all activities of daily living. There are currently no nursing homes with the staffing capacity to keep him safe without full restraints.*
>
> *S. has two paid caregivers and also needs daily range-of-motion and cognitive therapy to help him maintain functioning. In the home setting, he does not need physical restraints as his caregivers watch him continuously. He has breathing problems, so he needs close monitoring when taking medication, drinking, or eating. He goes to adult day care a few days a week. Although his family has been supportive, the stress of caring for S. is great.*

There are currently 566 commercial adult foster care homes in Multnomah County, of which 65% are for seniors and people with disabilities, along with 345 relative foster homes. Most long-term care facilities in the state are licensed, inspected, and monitored by the Seniors and People with Disabilities (SPD) Division of the Oregon Department of Human Services. However, in Multnomah County, commercial adult foster care homes are inspected, monitored, and licensed locally through the Adult Care Home Program (ACHP), also in ADS.

> *R. is a 92-year-old woman whose primary diagnosis is congestive heart failure. She has been in the Medicaid LTC Program for a little over one year. She has about $1,300 per month in SSI and pension income. She was placed in an adult foster care home, and she also participates in a special program for seniors operated by a local hospital. She has a Program case manager but receives all of her services through the hospital's special program, including medical care, a day center program, physical and occupational therapy, social work support, and monitoring of her heart condition.*
>
> *R. is close to her family and they have assisted her in making choices about placement and care. She was reluctant to move into an adult foster home, and her son was also concerned. But, he now reports that he is pleased with the care his mother receives there and that she is happy and feels like she is part of an extended family. R. has gained some strength in her new care setting. She is working hard to be able to walk again and to regain some flexibility in her shoulders. Her goal is to become as independent as possible.*

In FY2007, there were 1,154 Medicaid LTC Program clients placed in adult foster care homes, making up about 20% of the total caseload. The large majority (72%) were placed in commercial foster homes, with only 28% placed in foster care homes operated by relatives. Although ACHP has worked to expand the capacity of foster care homes licensed to take physically disabled

clients, foster care placement rates were still higher for seniors in the Program (23%), compared to 13% for younger disabled clients.

We found that clients with the highest need levels (***SPLs*** of 1-4) were those with the highest foster home placement rates (27%). Over 80% of the Program clients in foster care were case managed at the Mid County and East Branches located in the parts of the county where the majority of these homes are located. Clients of Asian heritage had the highest foster care placement rates (32%) and African Americans the lowest (12%).

> *D. is in his early 60's and has lived in a specialized adult foster home for over a year. He was a university professor and published author who developed a degenerative brain disease and requires 24-hour care due to behaviors and risk of self-endangerment. D. is gradually losing his ability to reason, act appropriately on his own behalf, and live independently in the community. He exhibits very challenging behaviors and is frustrated by his own intermittent recognition of his diminished mental capacity.*
>
> *D. enjoys visits from his wife and son and listening to classical music. His family is supportive but struggles to reconcile his current condition with the memory of the vibrant husband and father he once was. His disease is unusual and puzzling, and manifests itself in a frustrating array of cognitive and sensory deficits.*

Assisted Living Facilities

Assisted living facilities are licensed 24-hour care settings for six or more residents in private apartments. There are currently 21 assisted living facilities in Multnomah County that take Medicaid clients. Most units have kitchenettes with a sink, refrigerator, and cooking appliance, as well as wheelchair-accessible bathrooms with showers. Services may include meals, personal care services, medication management and health care monitoring, laundry and housekeeping, and recreational activities.

Only 7% of Program clients opted to live in an assisted living facility in FY07. Assisted living placement rates were highest for clients requiring relatively low levels of assistance (15%). This option was used more frequently for seniors (9%) than for younger disabled clients (4%). Placement rates in assisted living facilities were highest in the N/NE Branch (20%), suggesting that the majority of such facilities licensed with the state and willing to take Medicaid clients may be located in that region of the county. Fewer clients may have qualified for assisted living based on the level of independence generally needed to live in an assisted living facility.

Residential Care Facilities

Residential care facilities are licensed 24-hour care settings which can serve six or more residents in private or shared rooms. There are 45 residential care facilities in Multnomah County ranging in size from six beds to over 100. Residential care facilities and assisted living facilities provide the same level of care with central dining rooms, nurse consultation, housekeeping, and medication monitoring.

There were about 500 clients in residential care facilities, which made up about 9% of Program clients. This placement option was used more extensively for seniors (10%) than for younger disabled clients (6%). About 60% were case managed out of the Mid County and East Branches,

where the majority of these facilities are located. Less than 2% of the clients placed in residential care facilities had limited English language proficiency.

> *G. is 69 years and lives in a residential care facility, the RCF. Like many in this facility, G. not only requires assistance with medical and physical issues, but also has a mental health diagnosis that impacts his ability to live independently and care appropriately for himself. G. takes psychotropic medications and needs assistance with bathing, hygiene, dressing, and cognition, along with meal preparation, housekeeping, and laundry.*
>
> *Staff at the RCF develop individual plans, and they work to enable clients to remain at the facility rather than transferring them to a nursing home when their health declines or changes.*
>
> *G. has good rapport with other residents at the RCF, but he has declined involvement in any outpatient programs. He checks in at least once a day with his case manager and also with friends and family who currently live in other parts of the state. He is alert and oriented and has a basic understanding of his mental health and medical needs, although he still requires assistance from staff and others. He has a history of failing in the community when left to his own means and without routine and a structured setting.*

Specialized Living Facilities

Specialized living facilities provide care in a home-like setting for clients with specialized needs, such as quadriplegics or those with brain injuries. Generally, residents are provided with a live-in attendant who provides 24-hour care.

> *K-House is a 24-hour specialized living facility designed for those with brain injuries. Usually residents can move around independently, but they need constant cuing and supervision to complete some self-management tasks. Residents each live in their own apartments, and they must be mobile, able to dress themselves, and handle their own grooming and bathroom needs.*
>
> *Residents at K-House are involved in a special program which has them maintain a memory book and use a 3X5 card to track daily information. The typical client is unable to problem solve and has difficulty holding or processing new information. They may recognize a problem but not have the awareness to solve it. They tend to need a high level of structure with constant supervision and cuing. When ready, clients can move into more independent living situations.*

There were only 88 clients in Multnomah County placed in a specialized living facility in FY07. The majority was younger disabled clients (59%), and they were managed out of the Mid County and East Branches. About 72% of these clients had ***SPLs*** of 1-3, indicating a high level of cognitive impairment.

One specialized living facility is a combination 24-hour care environment in an apartment setting. In order to live on the first floor of the facility, individuals must not have significant night-time needs and be able to direct their own care. The upstairs apartments are for other clients in the

Program who have in-home care providers. Because these facilities are available through subsidized housing, residents pay a reduced rent and are able to receive food stamps.

J. is 42 and has been in the Medicaid LTC Program since 2002. She is completely wheelchair bound and has a range of physical and mental health diagnoses including spina bifida, obesity, auto-immune disease, asthma, apnea, fibromyalgia, and depression. She lives in a specialized program called the SLF Apartments and needs assistance with bathing and grooming, as well as with housekeeping, laundry, meal preparation, and cognition.

If a facility like the SLF Apartments were not available, J. would most likely be in an adult foster home with much older individuals. The care she receives living at the SLF Apartments allows J. to independently reside in a regular apartment complex, but also provides her support when she needs it.

Nursing Facilities

Nursing facilities are the most expensive and most restrictive of the long-term care options. As of June 30, 2007, there were 1,217 Medicaid LTC Program clients placed in nursing facilities, or 21% of the total caseload. About 79% of these were classified as requiring full assistance based on their ***SPLs***.

Nursing facilities can make 24-hour care available to a larger numbers of residents in an institutional setting. There are currently 34 nursing facilities in Multnomah County licensed to accept Medicaid clients. Nursing facilities are often used on a temporary basis for those discharged from hospital care after an accident, surgery, or serious illness until they can return to caring for themselves. For others, nursing facilities may be a long-term placement when clients require both high levels of personal and medical care on a 24-hour basis and cannot be placed in an alternative community-based facility.

Age is correlated with nursing facility placement. While 15% of the seniors in the Program who are 65 - 74 years old are placed in nursing facilities, the rate for seniors 85 and older is 29%.

H. was recently placed in a nursing facility after several failed attempts to keep him at home. He is 81 years old and was initially referred to the Medicaid LTC Program intake while recovering from a fall in his home. He was provided with home care worker assistance, but he fired his home care worker after two weeks. The home care worker had reported that his house was a fire hazard, so his case manager hired a contract agency to provide care. However, H. refused to allow agency staff into his house.

H.'s subsequent problems with home care workers, along with falls and other health issues requiring hospital stays, prompted his case manager to order a psychological evaluation. It was determined that H. was having hallucinations and delusions, and he was discharged to another nursing facility where he currently resides. His case manager visited several months after placement and found that H. had no desire to return home.

Recommendations

As ADS and the state look to the future to find ways to provide services to an increasing number of seniors and people with disabilities, we recommend that they make it a priority to develop more streamlined information systems. These should provide ADS with adequate data to better manage clients and services, as well as plan effectively for the future.

I. We recommend that ADS work with the state to develop a solution for discrepancies in its View Direct reports, particularly those relating to clients receiving state Personal Care Services Program and those placed in specialized living facilities. Such discrepancies may call for modifications to ADS' monthly client reports and caseload reporting for funding allocations.

II. We recommend that ADS work with county IT to develop an online Branch Monthly Activities Reporting (BMAR) system (including intakes and caseloads) and develop guidelines so that data are more consistently reported.

III. We recommend that ADS find ways to classify and collect data on clients with mental health and behavioral challenges. These harder-to-serve clients have workload implications for the Program. ADS should explore expanding supports and services for clients with mental health and behavioral issues.

IV. We recommend that ADS consider expanding the county's capacity to serve the growing number of minority clients and those with limited English proficiency, with particular attention to community-based facilities for ethnic minorities and other potentially underserved populations.

V. We recommend that ADS work with the state to ensure that the infrastructure supporting home care workers (including registration, training, and monitoring functions) is equipped for the increased demand for their services in the future.

Responses to Audit

Ted Wheeler, Multnomah County Chair

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Portland, Oregon 97214
Phone: (503) 988-3308
Email: mult.chair@co.multnomah.or.us

To: LaVonne Griffin-Valade, County Auditor

Fm: Ted Wheeler, Multnomah County Chair

Re: Medicaid Long-term Care Program Audit

Dt: July 29, 2008

Thank you for your audit of the Medicaid Long-term Care Program. As you know, Multnomah County is justifiably proud of our efforts to help seniors and people with disabilities to avoid costly nursing home placements.

I enthusiastically endorse your call to make better use of data but note that there are obstacles. First, we rely on statewide data systems and we need the state to make changes in those systems in order to have better data. In addition, budget reductions have forced hard choices and the Department has appropriately prioritized direct service to clients over other important activities. I note that the Division has recently added more analysis capacity and I am confident that they will continue to make progress. It is reassuring to me that your audit confirms that they are moving in the right direction.

Because of the ongoing structural deficit that we face, Multnomah County will continue to be forced to make choices between providing direct services and investing in management systems to deliver services more efficiently. We welcome your input as we wrestle with the tradeoffs between serving clients and collecting data. Working together, I hope that we can develop a better understanding of the costs and benefits of specific potential improvements so that we can prioritize the steps that will yield the best return.

In addition, I will propose to the Board of County Commissioners that we encourage the Oregon Legislature (as part of our legislative advocacy agenda) to support changes to statewide data systems so that those systems can provide more useful information to managers. I hope that you will share your audit findings with state legislators

Thank you for all of your hard work on behalf of the taxpayers of Multnomah County.

Department of County Human Services

MULTNOMAH COUNTY
OREGON

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MEMORANDUM

TO: LaVonne Griffin-Valade, Auditor
Multnomah County

FROM: Joanne Fuller, MSW, Director
Department of County Human Services

DATE: July 14, 2008

SUBJECT: ADSD Medicaid Long-term Waiver Program Audit Follow Up Response

The Department of County Human Services (DCHS) and the Aging and Disability Services Division (ADSD) acknowledge the time that you and your staff have invested in a review of the ADSD Medicaid Long-term Waiver Program, which serves very low-income seniors and disabled adults eligible for nursing home care. I would like to thank you for your recommendations and appreciate the opportunity to comment on your findings and recommendations.

I have reviewed the audit findings for the Medicaid Long-term Care Program and generally agree with the recommendations, particularly around the need to improve access to and reliability of client related data obtained by the state, as well as the need to enhance our capacity to serve the growing number of minority and limited English speaking clients.

Streamlining and developing information systems has been a priority for ADSD and I agree with recommendations related to improving access, accuracy and reliability of data obtained from state systems for program management. We appreciate the fact that your report supports needed actions that ADSD has already taken to identify and address the needs of our growing minority population. ADSD completed a study to identify service improvements for clients with limited English proficiency earlier this year and has developed a detailed action plan to respond to the findings.

Lastly, while shared program responsibility for various aspects of the Home Care Worker Program and state ownership of our primary data system present challenges for ADSD I concur that there are possibilities to collaborate and strategize with the Oregon Home Care Commission to improve performance in these areas as well.

Thank you for the care you took to complete this study and for taking the time to include the many valuable client profiles. The recommendations in this report will assist us in advancing our goal for improved access and utilization of data, and improving service to our clients. We look forward to reporting on our progress to explore and implement these recommendations.

cc: Mary Shortall, Division Manager– ADSD
Ted Wheeler, Multnomah County Chair

List of Exhibits

Appendix A - Detailed Methodology

Our analyses of Medicaid LTC Program clients, services and costs were based on computerized data files obtained from both the state and ADS. We obtained from the state Seniors and People with Disabilities (SPD) Division computerized data on all claims filed for Multnomah County clients served under the Oregon's Medicaid long-term care waiver over a five-year period (July 1, 2002 thru June 30, 2007). The state data included claims for nursing facility clients. It also included claims for state Personal Care Program services to clients not eligible for services under the waiver, but these claims records were excluded from most audit analyses. State claims data included a relatively small number of claims classified as nursing facility claims for care in specialized facilities (eg. Pediatric and Post-Hospital Extended Care). We generally excluded these claims from our analysis because the state does not report them in most statistical reports on Medicaid long-term care clients. State claims data did not include clients served in Multnomah County through Providence ElderPlace (a capitated medical and long-term care program funded through Medicaid and Medicare). Because of data limitations we were unable to evaluate non-medical transportation services and costs provided through contracts.

We also obtained five cross-sectional computerized files from county IT on active Medicaid LTC Program clients as of June 30th for each of the years 2003 through 2007. These files were generated from extract files from Oregon ACCESS, the state system for documenting client eligibility and developing case plans. Data files provided by IT included multiple records for each client associated with more than one case manager. We used payroll data to flag records associated with Case Manager II positions and Senior Case Managers, since these employees are assigned to provide case management under the waiver. Clients not associated with one of these case managers were not included in our audit analysis. We also excluded clients with ***SPLs*** over 13 not eligible for services under the Medicaid long-term care waiver, who may have received state Personal Care Program services or case management services under another special program such as Oregon Project Independence. Although the ADS data provided to us did not allow us to identify individual clients served through Providence Elderplace, we believe they were included in any analysis based on ADS data.

Data from both sources were tested extensively and calibrated against current and historical statistics in both state and ADS management reports. Control totals came close to, but never replicated reported totals exactly. We report a few significant deviations in our audit report. Because of differences between the two types of data, state and ADS client totals could not be reconciled. As noted above, some clients were included in one source but not the other. ADS data from the Oregon ACCESS system generally overstates client totals relative to the claims data from the state system, since these extract files include as active the new clients eligible for services whose claims have not yet been processed. Further, ADS staff reported to us that the Oregon ACCESS system does not have good controls for moving clients from active to inactive status, once they are no longer receiving services.

Staff caseloads were evaluated against ADS case manager workload standards based on computerized payroll data for ADS and our client data from the Oregon Access files. Caseload analysis focused on ongoing case managers (Case Manager II positions) and Medicaid waiver clients only. Case managers carrying caseloads of 26 or fewer clients were excluded from these calculations.

In order to assess trends in the intake of new clients, we analyzed ADS' monthly Branch Management Activity Reports (BMAR). To clarify the future demand for long-term care services in Multnomah County, we utilized projections by the Oregon Office of Economic Analysis.

Appendix B - Selected Bibliography of Long-Term Care Reports and Resources

Web sites

Each of the following web sites has program descriptions, consumer guides, publications, and links to advocacy and advisory groups and other resources for both senior services and disability services on county, state and federal levels.

- **Network of Care** - Network of Care is a comprehensive, Internet-based resource for the elderly and people with disabilities, as well as their caregivers and service providers. The site is a cooperative project of the Oregon Association of Area Agencies on Aging and Disabilities and the Department of Human Services. Funding for the site is from the Older Americans Act and Oregon Project Independence. http://networkofcare.org
- **Multnomah County, Department of Human Services, Aging and Disability Services Division** – At Multnomah County Aging and Disability Services, our mission is to assist older adults and persons with disabilities to live as independently as possible with a range of accessible, quality services that meet their diverse needs and preferences. - http://www.co.multnomah.or.us/ads
- **State of Oregon, Department of Human Services, Seniors and People with Disabilities Division** – This Web site is part of our mission to assist older Oregonians to achieve well-being through opportunities for community living, employment and services that promote choice, independence and dignity. - http://www.oregon.gov/DHS/spwpd
- **Federal Government – Department of Health and Human Services, Administration on Aging -** Our site is designed to provide a comprehensive overview of a wide variety of topics, programs and services related to aging. Whether you are an older individual, a caregiver, a community service provider, a researcher, or a student, you will find valuable information provided in a user-friendly way. http://www.aoa.gov/
- **Federal Government – Department of Health and Human Services, Office on Disability** - The Health and Human Services Office on Disability was created in October 2002 in response to President Bush's New Freedom Initiative (*NFI*). The office oversees the implementation and coordination of disability programs, policies and special initiatives pertaining to the over 54 million persons with disabilities in the United States. http://www.hhs.gov/od/
- **The Eldercare Locator** - a public service of the U.S. Administration on Aging. The Eldercare Locator is the first step to finding resources for older adults in any U.S. community. Just one phone call or Website visit provides an instant connection to resources that enable older persons to live independently in their communities. The service links those who need assistance with state and local area agencies on aging and community-based organizations that serve older adults and their caregivers. http://www.eldercare.gov/eldercare/Public/Home.asp
- **California Center for Long-Term Care Integration** – This library has some good studies and resources, although these are dated as the library has not been updated for some time. - http://www.ltci.ucla.edu/index.php

Consumer Resources

- ***The Resource Directory for Older People*** is designed to help people find the information they need. A cooperative effort of the National Institute on Aging (NIA) and the Administration on Aging (AoA), the directory is intended to serve a wide audience including health and legal professionals, social service providers, librarians, and researchers, as well as older people and their families. The directory contains organizational names, addresses, phone numbers, and fax numbers, as well as email and website addresses. http://www.aoa.gov/eldfam/How_to_Find/ResourceDirectory/resource_directory.asp

- ***Housing Options for Older Adults – A Guide for Making Housing Decision***s, This guide provides pros and cons for living situations from home ownership to various community based care facilities, including nursing homes. For more information on housing options, or on programs or services for older adults, it can be helpful to call the Eldercare Locator at 800.677.1116 or the American Bar Association (ABA) Commission on Law and Aging at 202.662.8690. Additional key resources are indicated throughout this booklet. http://www.eldercare.gov/Eldercare/Public/Home.asp

- ***The Employer's Guide*** – Most of those who qualify for homecare worker services have not been in the position as an employer. This guide provides information and resources to help with the hiring and managing of a homecare worker as an employer. http://www.oregon.gov/DHS/spd/pubs/index.shtml#brochures

- ***Home Care Worker Guide*** - This guide is a resource for Homecare Workers (HCWs) in the Client-Employed Provider (CEP) Program. As a HCW you may be involved in providing a wide range of in-home services, including support and assistance with activities of daily living, to enable your employer to continue to live in his or her own home. http://www.oregon.gov/DHS/spd/pubs/index.shtml#brochures

Reports

- ***2008-2011 Area Plan Summary*** - Multnomah County Aging and Disability Services. Mission, Vision, and Values; Overview of ADS Programs; Profile of Population ADS serves; ADS's Planning Process; Changes Planned for the Service System; Goals for 2008-2011. Report by Department of County Human Services dated October 2007. www.co.multnomah.or.us/ads/ads20082011_areaplan_summary.pdf

- ***Recommendations on the Future of Long-Term Care in Oregon*** – Department of Human Services, Seniors and People with Disabilities, May 2006. www.oregon.gov/DHS/spwpd/ltc/fltc/report1.pdf

- ***The Governors Commission on Senior Services Reports –*** The Governor's Commission on Senior Services is an official state commission made up of volunteers appointed by the governor and two legislators, one from the House and one from the Senate. The following reports and studies from the commission can be found at ww.oregon.gov/DHS/spd/adv/gcss/fltc_rpt.pdf

    - ***Riding the Wave: A call to action***
    - ***A Study of the Mental Health and Addiction Needs of Oregon's Baby Boomers September 2001***
    - ***Services for Ethnic Minority Seniors in Oregon***
    - ***The Quality of In-home Care Services in Oregon's Long Term Care System***

- ***A Profile of Older Americans: 2007*** – Report by Administration on Aging, U.S. Department of Health and Human Services. This is an annual report which provides demographics and projections about older Americans. Principal sources of data for the Profile are the U.S. Bureau of the Census, the National Center on Health Statistics, and the Bureau of Labor Statistics. The Profile incorporates the latest data available but not all items are updated on an annual basis. http://www.aoa.gov/prof/statistics/profile/profiles.asp
- ***Family Caregiver Support: State Facts at a Glance*** provides a compendium of information about family caregivers of older Americans and the state-level programs that serve them. These profiles were developed by NASUA in collaboration with the National Conference of State Legislatures, (NCSL) and funded by the U.S. Administration on Aging. The project was designed to educate state legislators about caregiver programs in their state. http://www.nasua.org/familycaregiver/statefacts.htm
- ***History of Long Term Care –*** *by* Karen Stevenson, ElderWeb Publisher. This section of ElderWeb is a comprehensive overview of how our long term care system has evolved by examining the events and decisions that changed the way that we have provided and paid for the care of our elderly over the years. [note: this is a wonderful document – worth the time to review] http://www.elderweb.com/home/book/export/html/2806
- ***Creating New Long Term Care Choices for Older Americans - A Synthesis of Findings from a Study of Affordable Housing Plus Services Linkages*** - 2006, American Association of Homes & Services for the Aging and the Institute for the Future of Aging Services. http://www.futureofaging.org/publications/
- ***Celebrate Long-Term Living Annual Report 2005*** – U. S. Administration on Aging. This report provides a good background about the Administration on Aging and its programs. http://www.aoa.gov/about/annual_report/2005_Final_Annual_Report.pdf
- ***Using Medicaid to Cover Services for Elderly Persons in Residential Care Settings: State Policy Maker and Stakeholder Views in Six States***, December 2003, U. S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. This report describes how six states use their Medicaid programs to fund residential care services for elderly persons. Oregon is one of the six states covered in the report. http://aspe.hhs.gov/daltcp/reports/med4rcs.htm
- ***Money Follows the Person Project - On the Move in Oregon*** - Oregon Department of Human Services, Seniors and People with Disabilities Division, Operational Protocol Submitted: January 29, 2008 . www.oregon.gov/DHS/spd/mfp/
- ***Global Age-Friendly Cities: A Guide*** – World Health Organization. Portland, Oregon was one of 33 cities throughout the world included in this study of the needs of elderly people living in cities. http://www.who.int/ageing/age_friendly_cities/en/index.html

Other ***Audits***

- ***Washington Medicaid Study*** - by State of Washington, Joint Legislative Audit and Review committee (JLARC), January 7, 2004. Although Medicaid for each state is administered differently, this audit provides some fundamental concepts about Medicaid in state governments. www.leg.wa.gov/jlarc/
- ***The U.s. Governmental Accountability Office*** has a large number of audits, reports and studies which were useful for this audit. Their reports can be found at http://www.gao.gov/ and searched for by topic or keyword.

Audit Criteria Resources

- State Agreement with County: State of Oregon Intergovernmental Agreement between Multnomah County, Aging and Disability Services and Oregon Department of Human Services, Senior & People with Disabilities (SPD) Division, dated July 1, 2007 – June 30, 2009.
- Federal Government Agreement with State: Application for a Section1915 © HCBS Waiver submitted by State of Oregeon, Department of Human Services. Brief description Oregon Department of Human Services (DHS) requests renewal waiver #0185.90.R2 to continue long-term community-based services for individuals who are aged (age 65 and above) or physically disabled (age 18 or above). These services are administered by DHS, Oregon's single state Medicaid agency, through its Seniors and People with Disabilities (SPD) Division. Effective Date, October 1, 2006.
- *Case Management in Long-Term Care Integration: An Overview of Current Programs and Evaluations* – Written for the California Center for Long-Term Care Integration, November 2001, by Andrew E. Scharlach, Ph. D, Nancy Giunta, M.A., and Kelly Mills-Dick, M.S.W.; University of California, Berkley, Center for the Advanced Study of Aging Services. http://cssr.berkeley.edu/aging/ see also http://www.ltci.ucla.edu/

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Audit Report: *Aging & Disabilities Services: Medicaid Long-term Care Program*
Report #08-06, July 2008
Audit Team: Judith DeVilliers, Principal Auditor
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Susan Luce, Audit Intern

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