Meeting Summary

Joint Task Force on Hospital Discharge Challenges
Meeting #5
Link to Task Force on OLIS

LPRO
LEGISLATIVE POLICY AND RESEARCH OFFICE

Date/Time	January 26, 12-3pm (link to recording)
Attendees	Chair Jimmy Jones Vice-Chair Elizabeth Burns Sen. Deb Patterson Phil Bentley Rachel Currans Henry Jeff Davis Eve Gray Felisa Hagins Jonathan Eames Trilby de Jung Jesse Kennedy Raymond Moreno Joe Ness Jonathan Weedman Jane-ellen Weidanz Dawn Wipf Excused: Rep. Christine Goodwin Daniel Davis Kathleen LeVee Alice Longley-Miller Leah Mitchell Sarah Ray
Opening remarks and 2024 Work Plan (staff slides)	Chair Jones thanked members for their flexibility in rescheduling the Task Force's January meeting due to the ice storm. Vice Chair Burns offered opening remarks. Staff reviewed a revised draft 2024 Task Force workplan. The workplan was developed from the direction of HB 3396, member input, and the availability of data and analyses, and revised based on member input. Changes are in a revisions log in the meeting materials. The plan can continue to change based on member needs going forward. If members would like to request specific data or analyses be considered for upcoming meetings they may direct questions or suggestions to Chair Jones and Vice-Chair Burns.
Introducing Consultant ATI Advisory • Brianna Ensslin Janoski • Fred Bentley • Brian Fuller • Cleo Kordomenos	ATI Advisory has been contracted to provide analysis and consultation to the Task Force. ATI is a national research and advisory firm that works with states, payers, providers, and foundations, on systems and policy issues related to complex care. The ATI team have experience supporting states in policy development related to Medicaid, Medicare-Medicaid integration, post-acute and long-term care practice, value-based care design, and past work evaluating the Oregon Health Plan.

ATI will provide four phases of analysis and support to the Task Force:

- Phase 1 (January to April 2024) assessment of Oregon's post-acute sector capacity (both facilities and workforce). Activities will include a survey of institutional and home-based providers; key informant interviews with providers and statewide associations, Coordinated Care Organizations, state and county agencies, and unions; and analysis of agency data on workforce trends.
- Phase 2 (February to May 2024) assessment of hospital discharge needs, processes, and outcomes. Activities will include additional key informant interviews, policy and document review, analysis of hospital stays, and analysis of staffing metrics for screening and placement staff.
- Phase 3 (March to June 2024) analysis of Oregon's benefit plan coverage, rates, and payment methods for post-acute care. Activities will include analysis of rates and trends among commercial and public payers supplemented with key informant interviews with state Medicaid plans and dual-eligible special needs plans (D-SNPs).
- Phase 4 (August 2024) final report with a summary of findings, as well as policy, program, and partnership opportunities for the Task Force's consideration as it develops recommendations.

Member questions included:

Q: Does ATI possess expertise related to hospital billing and reimbursement?

A: The broader ATI team includes people with this experience who are available for consultation. ATI does extensive work related to Medicare reimbursement (both Advantage and Fee for Service). The project design also includes direct engagement through interviews with hospital executives and staff to ensure their input is captured for the Task Force.

Q: How will the workplan align with the work ATI is going to be doing to develop analyses?

A: Task Force focused conversations in spring meetings will include ATI presentations. The workplan is iterative and members are encouraged to reach out to the chairs and staff at any point with questions or suggestions on the workplan.

Q: Will ATI be collecting information about other states' experiences with policies the Task Force is considering?

A: Where other states have implemented similar policies, ATI will gather information on how those policies are operationalized and any early information about outcomes.

Member Input on Scoping Questions

In addition to ATI, staff at LPRO, OHA, and ODHS are also gathering information and data to support the Task Force. Members discussed four areas where additional input was needed to scope those efforts.

Workforce Development

A wide range of occupations work in post-acute care, including:

- At least 32 distinct licensed and certified professions captured within the Oregon Healthcare Workforce Reporting Program database (as of January 11, 2023);
- Home care workers, personal support workers, and personal care attendants registered with the Oregon Home Care Commission;
- Seven professions certified through the Mental Health & Addiction Certification Board of Oregon;
- Direct care professionals who work in licensed post-acute care facilities and are not required to be licensed or certified.

Members discussed preferences to scope the Task Force's work on education, licensing, certification, and scope of practice. Member interests included:

- **Avoiding duplication of while providing input to other groups focused on statewide workforce shortages.** Future Ready Oregon's healthcare industry consortium has been asked to focus on pipeline development for Certified Nursing Assistants and other professions with identified shortages. The Governor's Office has requested an OHA workgroup established by HB 2235 (2023) focus on administrative policy barriers related to behavioral health workers. The Oregon Health Policy Board's healthcare workforce subcommittee strategic initiatives for 2024 include workforce development. Members desired to defer to these groups on topics related to scope of practice and licensing. Members were interested in providing input to these groups on opportunities to improve retention and reduce burnout in post-acute care.
- **Emphasis on staff that can provide more intensive medical or nursing care.** Members requested to understand post-acute facilities' unmet workforce needs for behavioral health, addiction care, and social care needs, explore how to develop additional roles or certifications for these, as well as specific coverage and payment models that can support the inclusion of these services in post-acute settings. Given the increasing complexity and acuity of post-acute care patients, members requested focus on RNs and therapists (occupational, physical, speech, and respiratory) that provide more intensive care, in addition to CNAs, LPNs, and direct care workers.
- **Expediting background check and credentialing processes and timelines by which workers become eligible to work in post-acute care.** Members requested information on licensure

and background check timelines, backlogs, and trends over time and across sectors. There is also interest in expediting credentialing processes specific to post-acute settings and exploring how Oregon could allow third party entities to submit paperwork on prospective employees' behalf.

- **Information on 2024 legislative concepts that require boards to allow temporary or provisional licenses for workers licensed in other states**. Members requested an update in March on LC 98 and 51, including what public testimony is offered in support or opposition during the 2024 short session, to inform the Task Force as it makes recommendations.

Presumptive Eligibility

Earlier in its work, the Task Force identified three coverage concepts for phase 1 exploration: 1) presumptive eligibility for Medicaid LTSS, 2) asset testing for Medicaid LTSS, and 3) Medicaid coverage of post-hospital extended care (skilled nursing). Members discussed presumptive eligibility to help staff gather additional information for future meetings.

Discussion included:

- How do states determine presumptive eligibility and how does it differ from state processes for full LTSS eligibility. Can we hear from other states about their processes?
- What aspects of the eligibility process are required under federal law and what do states have discretion over?
- From ODHS' perspective, what could be changed and would it be expected to help with discharge delays?
- When the state offered presumptive eligibility under federal emergency authority related to COVID-19, what percent were later determined ineligible? Could data from that period be used to estimate what percent of patients are likely eligible for LTSS and devise a presumptive eligibility mechanism to share risk with hospitals or others in situations where errors occur?
    - Per ODHS, during the pandemic, the state allowed self-attestation in place of asset testing but still required full functional screening for LTSS. ODHS prioritized patients who were in hospitals waiting to be discharged in order to address bed shortages during the public health emergency (PHE). Post PHE, the agency does not prioritize eligibility determinations for hospital patients on an ongoing basis because it would systematically delay applications for people needing services in their homes. ODHS is able to make retroactive payments to licensed care facilities to the date of acceptance, but they cannot do this for in-home services. If this approach was explored, it may warrant a different staffing model.

- What percent of hospital applicants for LTSS are already OHP-eligible and only need a functional assessment, versus those who are entirely new to OHP? Is there value in trying to streamline the determination process specifically for people who are already OHP-enrolled but only need the functional assessment?
    - Dawn Wipf noted that these current OHP cases are relatively straightforward and not the cause of delay in Asante. Hospitals can embed a case manager from the state to expedite those assessments. Delays are more often related to clients who do not already have Medicaid. In the past, a single case manager used to do both financial and functional eligibility screening and the process seemed to move faster. When the financial and functional assessment processes were split it appeared to result in slower processing.
- Has the state explored categorical eligibility (e.g., people already receiving other state or federal assistance could be automatically eligible for LTSS) rather than presumptive eligibility as an option to expedite LTSS determinations? Has the state considered a centralized data warehouse that would enable categorical eligibility across programs?
    - The ONE system for financial eligibility is newer and integrated but categorical eligibility would require the ONE system to interface with much older payment systems that are not integrated.
    - Private sector models for community information exchange may be relevant to this topic. *[Note: staff inquired about this topic after the meeting with Susan Otter at Oregon Health Authority's HIT Commons. She noted that CIE platforms used for screening and referral can provide a snapshot of community resource providers, but do not typically contain real-time information about placement capacity, limiting their utility for addressing discharge delays to community-based placements or shelters. CIE could provide more limited decision support to discharge planners as part of a workflow. Some third-party platforms such as GetHelp.com are aiming to facilitate discharge and placement but it is unclear to what extent these tools may be able to provide real-time bed capacity information.]*

Asset Testing

Members discussed Medicaid LTSS asset testing to inform further staff information gathering on this topic. Discussion included:

- Are asset tests relevant to the population of people who are experiencing delayed discharge? What is known about this?

    - Because the asset limit is $2,000 in liquid assets, assets like a second car or more than $2,000 in a bank account can disqualify an individual for LTSS even when they live close to the poverty line and do not have resources to privately purchase long-term care.
    - Members requested to consider options to disregard home equity if it encourages people to be treated in their homes.
    - Members requested further information from ODHS and OHA to understand pros and cons of liquid asset limits of varying levels.
- What options exist to modify the lookback period? Is this a federal requirement? What options do states have to modify this? Individuals are required to justify why net assets changed during the lookback period – not on a per transaction basis – which can be challenging for people who are cognitively impaired or who spent resources to remain in their own home but have trouble documenting these purchases.

Post Hospital Extended Care Benefit

Members discussed the Oregon Health Plan coverage of post hospital extended care (PHEC) to inform further staff information gathering on this topic. The Oregon Health Plan currently reimbursed up to but no more than 20 days of PHEC following prior authorization by a Coordinated Care Organization.

Discussion included:

- Why is Medicaid coverage of post hospital care capped at twenty days?
    - Under traditional Medicare, the first twenty days of post-hospital care are fully covered while days 21-99 are covered with a co-pay. Oregon's 20-day Medicaid benefit mirrors this traditional Medicare coverage and fully pays skilled nursing stays for the first twenty days but does not pay for additional days.
- Is data available on how average length of stay, emergency department utilization, hospital readmission, and initiation of in-home care varies across states with different levels of Medicaid coverage of skilled nursing stays?
- PacificSource developed an extension payment model for Medicaid members after learning that all skilled nursing facilities in Central Oregon were refusing Medicaid enrollees. SNF administrators who have accepted Medicaid patients can now request an extension from the CCO if they anticipate an enrollee will exhaust their 20-day PHEC benefit before they are ready for discharge to a lower level of care. They have seen improvement in placements with this approach and all three SNFs resumed accepting Medicaid enrollees. This extension payment was funded

through the CCO's budget but is not currently an option in fee-for-service Medicaid.
- Could the 20-day limit on SNF stays be changed to a requirement for reassessment every twenty days?

OHA has engaged their actuaries to develop budget estimates for the Task Force on the cost of increasing the 20-day limit for OHP-paid skilled nursing stays. OHA proposed modeling alternative coverage of 30, 60, and 100-day skilled nursing coverage. Feedback was requested on this proposed approach.

- Members requested analysis of the number of days of post-hospital care that are needed by Medicaid enrollees which could be used to develop recommendations to change the PHEC benefit.
- One example in support of a 60-day benefit is a patient who needs 6-8 weeks of intravenous antibiotic treatment. Hospitals may have to hold these patients until they only have twenty days of antibiotic treatment remaining, even when they are otherwise ready for discharge to a lower level of care at an earlier date.
- Post-acute facilities are reluctant to accept patients with substance use disorders who have IV drug ports for antibiotics because of the risk of overdose if patients use ports for other drugs. Additional solutions may be needed for these patients. There are outpatient programs in other states that could serve as a model for this issue.
- Members noted that changing OHP coverage of skilled nursing could result in a range of potential impacts, including reduced administrative burden involved in placement challenges, improved patient flow and fewer discharge delays.
- Members noted that any modeling of length of stay in skilled nursing needs to consider hospital readmissions. SNF stays that are shorter may be due to undesirable hospital readmissions. Members were also interested in how an increase in skilled nursing coverage could shift costs from hospitals to the state, how it would impact patient flow and access in emergency departments, and whether it would reduce the staffing burden on the state, hospitals, and post-acute facilities when coordinating placements.

Member input on coverage concepts and workforce topics will be considered as upcoming Task Force meetings are planned.

Public Comment	*None*

Meeting Materials	• *December 2023 Meeting #4 summary (link)*
	• *2024 Workplan*
	  ○ *Link to draft work plan*
	  ○ *Link to revisions log*
	  ○ *Link to staff slides*
	• *Introducing Consultant ATI Advisory (link to slides)*