Analysis of Benefits, Coverage, and Payment Policy for Post-Acute Care

ATI Presentation Slides for Select June JTFHDC Meeting Topics

Presented to the JTFHDC June 27th, 2024

ATI Advisory

NAVIGATING CONTENTS: MAPPING ATI PRESENTATIONS WITHIN JUNE MEETING TOPICS

Agenda Topic	ATI Segment(s) within Agenda Topic	Purpose within June Meeting	Corresponding Slides within ATI Deck
I. Preliminary findings from analysis of post-acute care wages and payments	▪ Medicaid Payment for LTSS and Post-Pandemic Trends Impacting Payment	▪ Provide national LTSS payment perspective and context to DHS/Burns findings from HCBS Rate and Wage Study	Slides 3-9
	▪ Payment Opportunities to Support Adult Foster Home Capacity for Complex Care Delivery	▪ Revisit discussion to-date on the critical role AFHs play in caring for individuals with complex care needs post-discharge; spotlight payment opportunity to support AFHs in Oregon	Slides 10-14
	▪ Analysis of Reimbursement Rate Trends to Select Post-Acute Care Providers	▪ Provide understanding of how payment to select PAC providers may be impacting hospital discharge challenges	Slides 15-20
II. Opportunities to leverage managed care authorities to promote timely and appropriate hospital discharges	▪ Promoting Timely and Appropriate Hospital Discharges through Managed Medicare and Medicaid Authorities	▪ Provide understanding of state levers to promote timely hospital discharge with appropriate supports through D-SNPs and CCOs	Slides 21-30
III. LTSS presumptive eligibility, asset limit, and PHEC concepts	▪ Overview of Flexibilities to Streamline and/or Promote Access to Medicaid LTSS	▪ Provide national overview of Medicaid LTSS presumptive eligibility and asset test policies and key state implementation considerations	Slides 31-41

AFH – Adult Foster Home; CCO – Coordinated Care Organization; D-SNP – Dual Eligible Special Needs Plan; LTSS – Long-Term Services and Supports

Overview of Medicaid Payment for LTSS and Post-Pandemic Trends Impacting Payment

AGENDA

- Medicaid's Role in Long-Term Services and Supports (LTSS)
- National Trends in Expenditures for Community versus Institutional LTSS
- Looking Ahead: Federal Changes Impacting Post-Pandemic State Medicaid Agency LTSS Payment Priorities

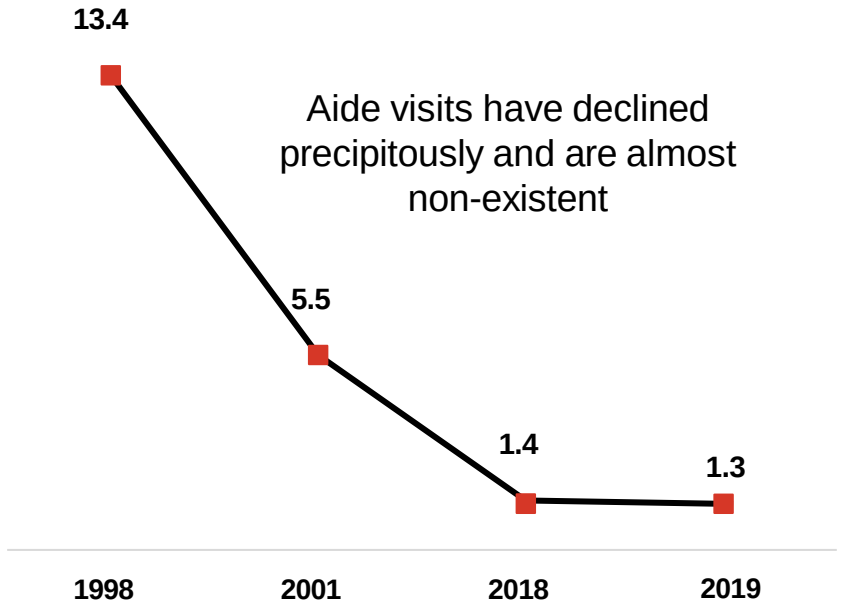
MEDICARE PAYS FOR MEDICAL CARE, NOT LONG-TERM SERVICES AND SUPPORTS (LTSS)

- Medicare pays for skilled nursing facility care, only after a hospitalization, and only up to 100 days per spell of illness.

- Medicare also pays for home health care for individuals who are homebound or who need intermittent or part-time skilled nursing services.

- Home Health provides:
  - Therapy (Physical, Occupational, Speech)
  - Part-time or intermittent skilled nursing
  - Very little use of home health aide care (“home care/personal care”)

Medicare Home Health Aide Visits Per Episode



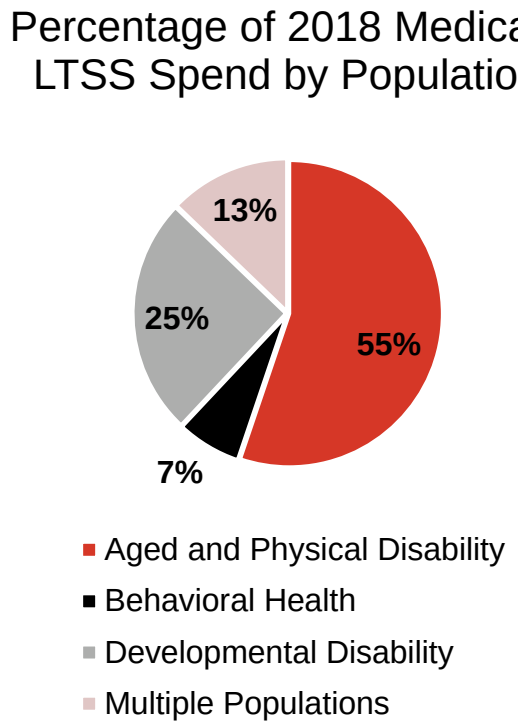
Source: MedPAC March 2021 Report to the Congress: Medicare Payment Policy; Table 8-1. Table source: MedPAC analysis of home health standard analytic file from CMS.

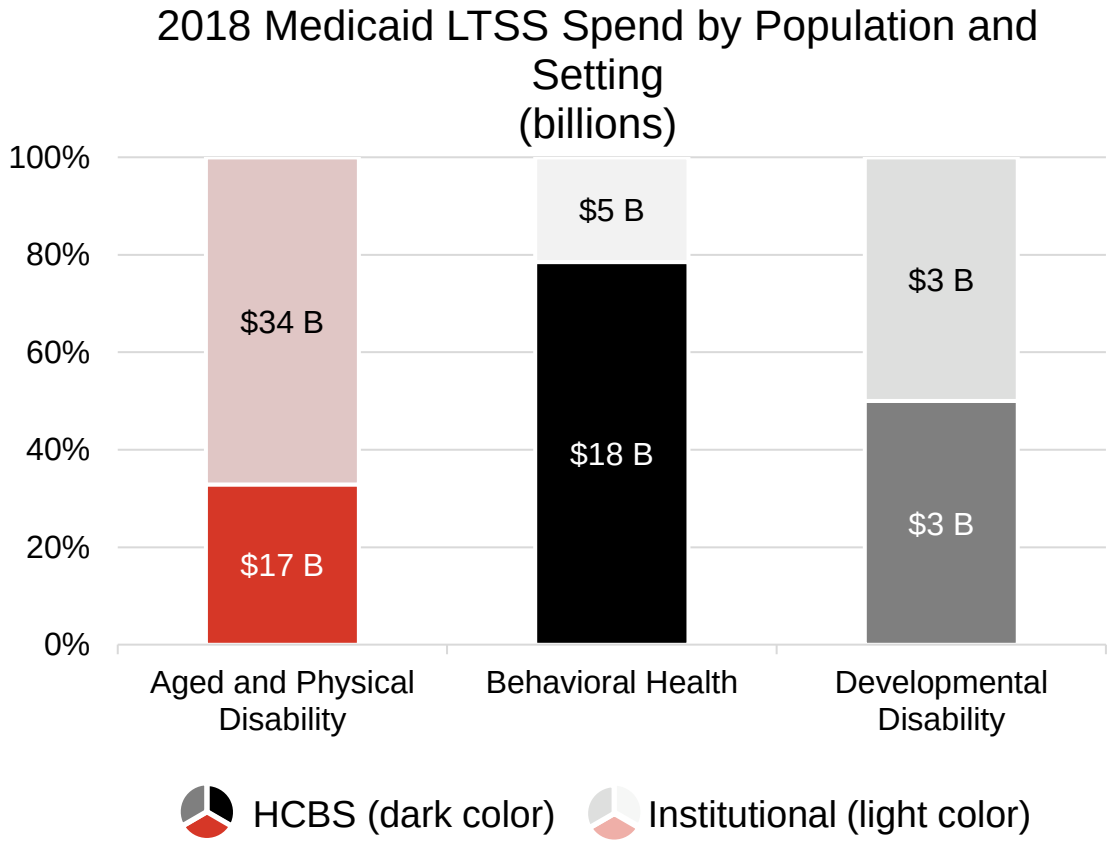
WHO PAYS FOR LTSS?

Third-Party Paid	• Medicaid is the primary third-party payer for LTSS	$215b
	• In 2019, Medicare Advantage plans started being permitted to cover limited LTSS-like benefits via supplemental benefits	*Nominal*
	• Other public programs (e.g., Older Americans Act) may cover limited LTSS	$104b
Private Pay	• People can pay for LTSS out of pocket and via private insurance	$83b*
Unpaid	• Family and other unpaid caregivers provide a significant amount of LTSS	$470b
Unmet	• Many individuals go without sufficient formal or informal LTSS	*Millions of individuals*

Source: https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/
Note the private pay number does not include assisted living facility services covered via monthly fees. This likely adds another $45 - $55b per year in private pay payments.

LTSS SPENDING SPANS DIVERSE POPULATIONS AND INCLUDES INSTITUTIONAL AND HCBS SETTINGS



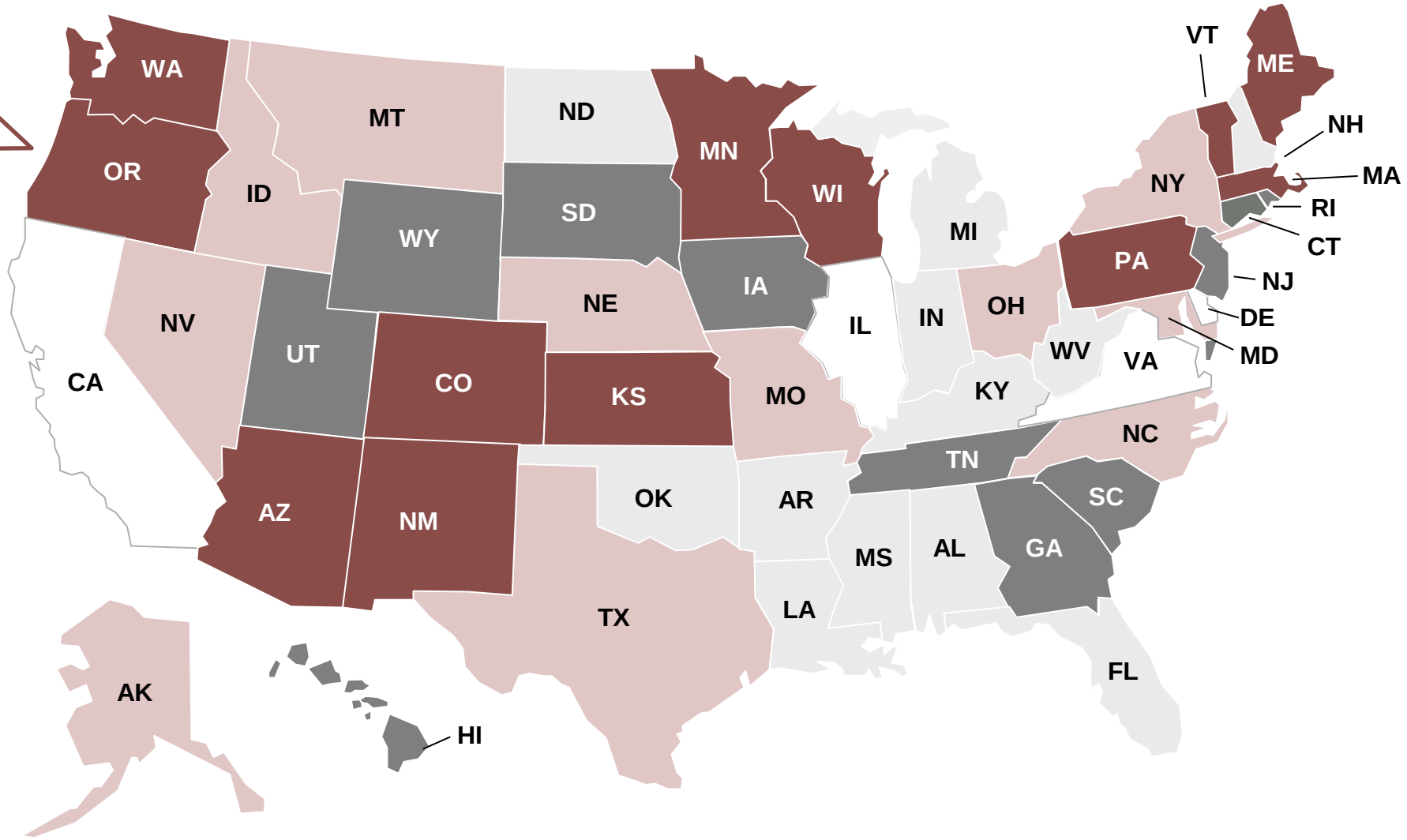


Source: Centers for Medicare & Medicaid Services & Mathematica. Medicaid Expenditures for Long-Term Services and Supports in FY 2017-2018. 2021.
Note: Due to recent shifts in the Medicaid authorities used to cover HCBS, these data are not available from CMS after 2018.

STATES VARY IN THEIR EXPENDITURES ON HCBS AS A PERCENT OF TOTAL MEDICAID LTSS EXPENDITURES (“BALANCE”)

Not available	33.4% - 47.3%	47.4% - 54.7%	54.8% - 63.2%	63.3% - 83.3%

Nationally, Oregon spends the highest share of Medicaid LTSS on HCBS (83.3%)



Source: Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019

LOOKING AHEAD: STATE HCBS PAYMENT PRIORITIES POST-PANDEMIC

Sustaining Success from Pandemic-Era HCBS Flexibilities & Funding

- Long-standing workforce challenges in Medicaid HCBS exacerbated by the pandemic; addressing them remains the top priority for most state HCBS programs.
- States made significant investments in HCBS and the related DCW workforce through enhanced federal funding for HCBS; sustaining success after time-limited funding ends will be a priority.

Implementing New Federal Medicaid Requirements

- Recent Medicaid rules (April 2024) impose new requirements for states about Medicaid payment rates and the percentage of states' payments that go towards worker compensation.*
- It remains to be seen how new requirements will affect state LTSS payments, though both new rules are likely to likely to put upward pressure on payment rates and spending on LTSS, with no additional federal funding.

DCW – Direct Care Worker

*Requires that at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for the direct care workforce: Ensuring Access to Medicaid Services (CMS 2442-P) Notice of Proposed Rulemaking.

Payment Opportunities to Support Adult Foster Home Capacity for Complex Care Delivery

AGENDA

- Adult Foster Home (AFH) Role in Serving Oregon Patients with Complex Needs After Discharge
- Current AFH Licensure and Reimbursement Challenges
- Opportunities to Support AFH Capacity: Washington Spotlight

AFHs PLAY A UNIQUE AND ESSENTIAL ROLE IN SERVING PATIENTS WITH COMPLEX NEEDS AFTER DISCHARGE

- Community-based residential care settings, such as ALFs, RCFs, and AFHs, are an appropriate care setting for many individuals with complex care needs, particularly for older adults and people with disabilities; however, current capacity is limited due to workforce and reimbursement constraints.

- AFHs surveyed in ATI's March 2024 survey reported the lowest rates of having problems accepting individuals with the following needs in the last month*:
  - Complex medical needs
  - Challenging behaviors
  - Homelessness or housing insecurity
  - Legal guardianship
  - Obesity
  - Low or no social supports

- Stakeholder interviewees to-date consistently report that AFHs are most readily willing to accept individuals with complex care needs from hospitals; however, insufficient payment creates challenges for these providers, as reflected in ATI's March 2024 provider survey.*

*Findings from ATI Advisory March 2024 survey of Oregon post-acute care providers, as presented at the April 2024 Joint Task Force meeting; Question was phrased: "In the last month, did your organization have any problems when trying to **accept** individuals with the following needs?" Respondents included APD and BH AFHs, but not IDD.

CURRENT AFH LICENSURE AND REIMBURSEMENT IN OREGON DOES NOT REFLECT NEED OR INTENSITY OF SERVICES PROVIDED

- AFHs are separately licensed to serve:
  - Older adults and adults with physical disabilities;
  - Adults with behavioral health needs; and
  - Adults with intellectual and/or developmental disabilities.
- AFHs licensed by APD can contract to provide special needs care at higher rates or request rate exceptions; these are reportedly insufficient to meet complex care needs.
- 63% of adult foster homes disagreed or strongly disagreed that payments sufficiently covered care for complex needs individuals, the highest of all provider types ATI surveyed.*
- AFH rates are negotiated through collective bargaining with State Employees International Union, 503 (SEIU).

Type of AFH	Average OR Monthly Medicaid Rate (2024)
Aging Patients and People with Physical Disabilities	$2,029 to $3,136
Mental Health and Addiction	$2,738
Adults with Intellectual and/or Developmental Disabilities	$3,500-$5,500; as high as $9,000 for exceptional needs
All types also receive a $733 room and board payment	

* Findings from ATI Advisory March 2024 survey of Oregon post-acute care providers, as presented at the April 2024 Joint Task Force meeting; How much will I get paid as an Adult Care Home operator? | Multnomah County (multco.us); rateschedule.pdf (state.or.us)

STATE PAYMENT POLICY OPPORTUNITIES TO SUPPORT AFH CAPACITY: WASHINGTON SPOTLIGHT

Washington state offers an example of AFH acuity-based payment that could incentivize greater capacity to treat patients with complex care needs.

	Approach Summary	Assessment	Process for Setting Base Payment Rates and Rate Updates	Oregon-Specific Considerations
	▪ AFHs in Washington are paid based on 17 unique classification groups that reflect levels of resources required. ▪ AFHs in Washington receive daily reimbursements for services provided ($100.67 on average). ▪ Daily reimbursements increase by about $110/day between Classification 1 ($123.95) and Classification 17 ($235.18) in King County as of July 2024. . ▪ For a 30-day month, the range in reimbursement is $3,400.20 to $6,293.10.	▪ State case managers evaluate clients using the CARE assessment tool to determine the level of resources needed to address the client's specific needs and assign clients to one of 17 CARE Classifications. ▪ The assessment considers cognitive issues, complex medical conditions, moods and behaviors, and ability to engage in Activities of Daily Living (ADLs).	▪ Medicaid reimbursements are subject to union negotiation with the State. The current contract lasts from July 2023 to June 2025. ▪ The state fully funded the union's Collective Bargaining Agreement in 2023, which included $339 million in new funds and a 29% increase in base daily payment. ▪ Providers receive additional daily increases to payments for individuals who require Expanded Community Services, Specialized Behavior Support, Community Integration, HIV/AIDS treatment, or Meaningful Day, regardless of county or CARE Classification.	▪ Like WA, OR contracts are subject to collective bargaining, which may influence potential changes. ▪ The current collective bargaining agreement ends on June 30, 2025. ▪ A bill was introduced, but not passed, in the 2023 legislative session to increase AFH rates temporarily and provide add-on payments.

Source: Analysis of the Washington Adult Family Home Services Medicaid Payment Methodology; 2023-25-CBA-Upcoming-Increases.pdf (adultfamilyhomecouncil.org); 2023 Legislative Session Overview; HB2495 2023 Regular Session - Oregon Legislative Information System (oregonlegislature.gov)

Analysis of Reimbursement Rate Trends to Select Post-Acute Care Providers

AGENDA

- National Context for Payment to Select Post-Acute Care Providers*
- Key Findings: Analysis of Post-Acute Care Payment Trends in Oregon
- Appendix: Overview of Methods and Key Definitions for Analysis

*Provider payments analyzed include skilled nursing facilities, home health, and dialysis centers

NATIONAL CONTEXT FOR PAYMENT TO SELECT POST-ACUTE CARE PROVIDERS

→ Public insurance programs, particularly Medicare, are the primary payers for skilled nursing facility, home health, and dialysis services.

→ The post-acute care industry has largely recovered from the disruptions caused by the pandemic and PHE.

- Volumes for most post-acute care providers have rebounded after dipping in 2020-2021.
- Providers have resumed normal financial operations after receiving a massive infusion of federal Provider Relief Fund (PRF) dollars during the PHE.

→ Post-acute care providers have also adapted to the new Medicare reimbursement models.*

→ Labor cost inflation continues to outpace Medicare and Medicaid reimbursement increases for many post-acute care providers; and the federal minimum staffing mandate for nursing homes is creating significant uncertainty for nursing homes.

- While Oregon already has some of the highest staffing minimums in the U.S., many Oregon nursing homes could be impacted by a federal minimum staffing rule.

PHE – Public Health Emergency
*Patient-Driven Payment Model (PDPM) for Medicare skilled nursing facility payment effective January 1, 2019. Patient-Driven Groupings Model (PDGM) for Medicare home health payment effective January 1, 2020

NO DRAMATIC REIMBURSEMENT CHANGES THAT ARE OBVIOUS "CULPRITS" FOR HOSPITAL DISCHARGE CHALLENGES, BUT PAYMENTS LIKELY OUTPACED BY LABOR COST INFLATION

Key Findings

- SNF rates increased across all payer types – SNFs saw rate increases across the board over the 2017-2022 timeframe.
- The reimbursement picture was mixed for HHAs and dialysis providers – Medicare rates either held steady or rose slightly for HHAs and dialysis centers, while Medicaid rates declined for these providers.
- Reimbursement trends held true across geographies and clinical conditions – The overarching SNF, HHA, and dialysis payment trends did not change significantly when we assessed reimbursement rates across regions and patient subpopulations.

Implications

- No evidence of significant reimbursement changes that could have led to discharge issues – ATI analysis did not uncover significant reductions across payers that would have forced post-acute providers to close or reduce capacity; the Medicaid reductions for dialysis providers were notable, but Medicare remains the biggest payer for dialysis centers, and Medicare rates rose slightly.
- However, reimbursement rates most likely did not keep pace with labor cost inflation – While ATI analysis focused on reimbursement trends, it is likely that Oregon post-acute providers' labor cost inflation outpaced any payment increases, thereby constraining post-acute providers ability to hire more staff.

HHA – Home Health Agencies; SNF – Skilled Nursing Facility

CHANGES IN REIMBURSED RATE PER SERVICE RENDERED FOR SKILLED NURSING FACILITIES, HOME HEALTH AND DIALYSIS CENTERS VARY BY PAYER

→ Medicaid reimburses the lowest rates for skilled nursing facilities and dialysis centers, compared to Commercial and Medicare reimbursement rates for these facilities.

→ Across all payers, reimbursement rates for skilled nursing facilities increased, whereas for home health and dialysis centers, reimbursement rate changes vary by payers.

Payer	Skilled Nursing Facilities		Home Health		Dialysis Centers	
	2022 Reimbursement Rate	Changes from 2017 to 2022	2022 Reimbursement Rate	Changes from 2020 to 2022	2022 Reimbursement Rate	Changes from 2017 to 2022
Medicaid-CCO	$350.90	▲ Increased by 47%	$132.49	▼ Decreased by 9%	$125.74	▼ Decreased by 36%
Medicaid-FFS	$341.89	▲ Increased by 20%	$141.52	▼ Decreased by 1%	$102.87	▼ Decreased by 66%
Medicare	$1,075.54	▲ Increased by 34%	$127.97	▲ Increased by 0%	$217.25	▲ Increased by 8%
Commercial	$673.79	▲ Increased by 14%	$176.84	▲ Increased by 18%	$430.99	▼ Decreased by 10%

Skilled Nursing Facilities: Producer Price Index for Nursing Facilities for each payer from Bureau of Labor Statistics was used to adjust to 2017 dollars. Home Health: Producer Price Index for Home Health agencies for each payer from Bureau of Labor Statistics was used to adjust to 2017 dollars Dialysis Centers: CMS ESRD Index levels was used to adjust to 2017 dollars for all payers. Source: ATI analysis of Oregon All-Payer All-Claims data, 2017-2022; all numbers are rounded to a whole number. 0% represents < |0.4%|.

DESPITE SIZABLE CHANGES IN MEDICAID CCO REIMBURSEMENT RATES FOR SOME SETTINGS AND PATIENT POPULATIONS, MEDICAID IS NOT A TOP PAYER FOR MOST PAC PROVIDERS

- Changes in Medicaid reimbursement rates across complex care diagnostic cohorts by provider follows statewide changes in Medicaid reimbursement rates for these providers.
- For skilled nursing facilities, Medicaid reimbursement rates for individuals with complex care diagnosis ranges from $340.80 (individuals with ADRD) to $379.49 (individuals experiencing housing insecurity).

Complex Care Diagnosis		Skilled Nursing Facilities		Home Health		Dialysis Centers	
		2022 Medicaid Reimbursement Rates	Medicaid Changes from 2017 to 2022	2022 Medicaid Reimbursement Rates	Medicaid Changes from 2020 to 2022	2022 Medicaid Reimbursement Rates	Medicaid Changes from 2017 to 2022
	***Statewide***	***$ 350.67***	▲ ***Increased by 46%***	***$ 132.58***	▼ ***Decreased by 9%***	***$ 125.51***	▼ ***Decreased by 37%***
	SMI	$ 359.47	▲ Increased by 40%	$ 131.98	▼ Decreased by 9%	$ 103.42	▼ Decreased by 56%
	SUD	$ 371.13	*Not reported due to insufficient sample size*	$ 130.59	▼ Decreased by 12%	$ 160.86	▼ Decreased by 37%
	Housing Insecurity	$ 379.49		$ 112.60	▼ Decreased by 28%	*Not reported due to insufficient sample size*	
	Frailty[1]	$ 343.04	▲ Increased by 65%	$ 106.66	▼ Decreased by 12%	$ 59.69	*Not reported due to insufficient sample size*
	ADRD	$ 340.80	▲ Increased by 64%	$ 117.05	▼ Decreased by 7%	$ 83.54	▼ Decreased by 54%
	Obesity	$ 366.62	▲ Increased by 41%	$ 135.20	▼ Decreased by 8%	$ 132.54	▼ Decreased by 45%

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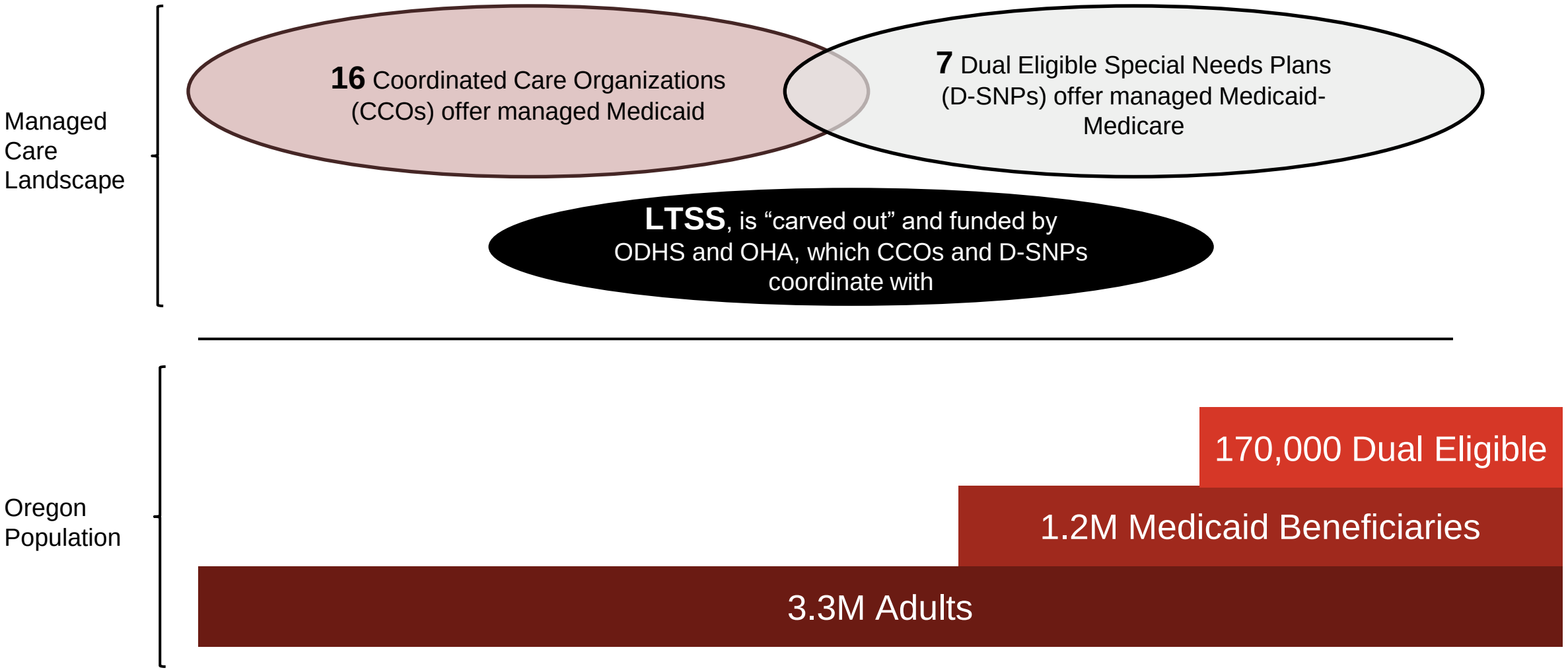
Skilled Nursing Facilities: Producer Price Index for Nursing Facilities for each payer from Bureau of Labor Statistics was used to adjust to 2017 dollars. **Home Health:** Medicare payments for Home Health changed to Patient-Driven Grouping Models, which includes shorten claims duration from 60 to 30days, as of January 2020. Producer Price Index for Home Health agencies for each payer from Bureau of Labor Statistics was used to adjust to 2017 dollars **Dialysis Centers**: CMS ESRD Index levels was used to adjust to 2017 dollars for all payers. **SMI** – Serious Mental Illness; **SUD** – Substance Use Disorder; **ADRD** – Alzheimer's Disease and Related Dementias 1. Frailty is limited to individuals age 65 years or older, as validated in the Kim Frailty Index. **Source:** ATI analysis of Oregon All-Payer All-Claims data, 2017-2022; Sample size less than 50 are not reported; Medicaid includes both CCO and FFS.

Promoting Timely and Appropriate Hospital Discharges through Managed Medicare and Medicaid Authorities

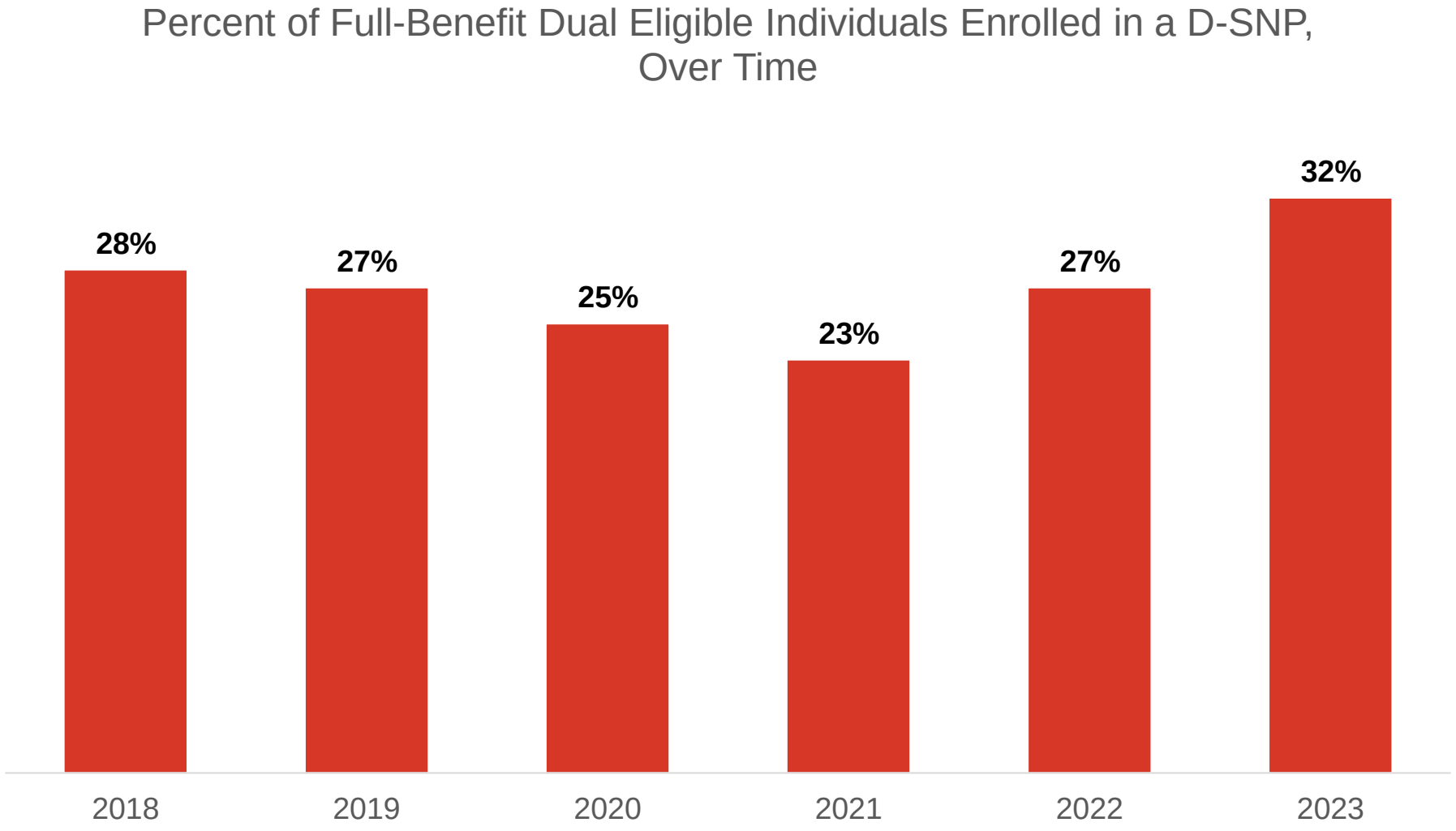
- Overview of Oregon Dual Eligible and Managed Care Landscape
- Overview of State Medicaid Agency Policy Levers over Managed Care
- Oregon Opportunities to Promote Timely and Appropriate Hospital Discharges through D-SNPs and CCOs

OVERVIEW: OREGON DUAL ELIGIBLE AND MANAGED CARE LANDSCAPE



Dual eligible beneficiary count - ATI Advisory State Resource Center.
Medicaid beneficiary count - State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data. February 2024.
Oregon population count - World Population Review.

OVERVIEW: D-SNP ENROLLMENT IS GROWING



State levers to influence care for dual eligible individuals has the potential to make an **outsized impact on Oregon's challenges**.

Dual eligible individuals have the longest average length of hospital stay in Oregon, use hospitals at high rates, and often have limited community resources.

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Source: ATI Advisory analysis of the CPSC file and the Medicare Master Beneficiary Summary File for December 2018-2022 and September 2023.
*ATI Advisory analysis of Oregon APAC data presented at the May 2024 Joint Task Force meeting.

OVERVIEW: STATE MEDICAID AGENCY POLICY LEVERS OVER MANAGED CARE

→ State Medicaid Agencies have three primary levers through which they can influence health plans' post-acute care capabilities and hospital discharge polices:

1

Dual Eligible Special Needs Plan (D-SNP) Contract

→ States with a D-SNP program can incorporate provisions in D-SNP contracts know as State Medicaid Agency Contracts (SMACs)

2

Managed Care Contract

→ States with Medicaid managed care can include requirements in **MCO contracts** and program monitoring

3

Managed Care Procurement

→ States with Medicaid managed care can evaluate prospective MCOs on the strength of their responses related hospital discharge process and post-acute care benefits through the request for proposals (RFP) process

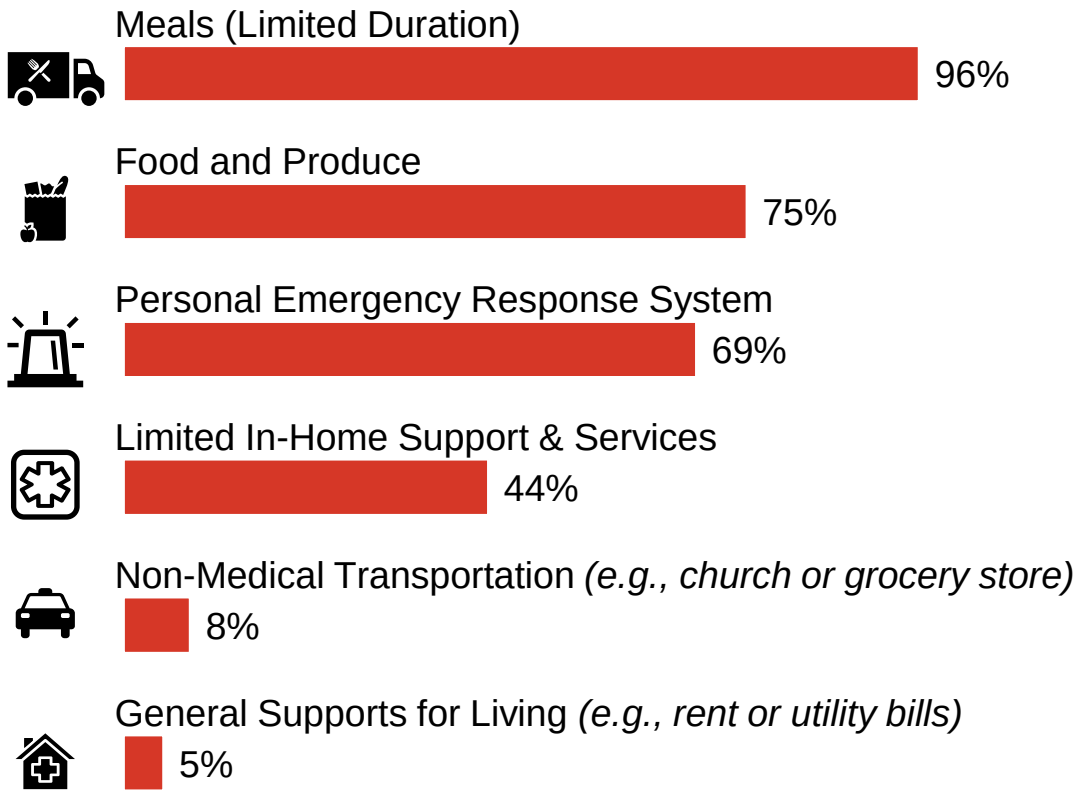
OVERVIEW: CONSIDERATIONS FOR USE OF LEVERS

Managed Care RFP		Managed Care / D-SNP Contract	
Opportunities	**Considerations**	**Opportunities**	**Considerations**
▲ Establishes CCO expectations early on in procurement process ▲ Provides opportunity to evaluate CCOs on strength of response to requirement	▼ To avoid protest, need to ensure fair evaluation of all questions and responses across CCOs ▼ States must perform extensive oversight to ensure CCOs implement RFP promises	▲ CCOs and D-SNPs have legal obligation to fulfill contract requirements ▲ States can amend contracts annually and, in some instances, more frequently than annual approval timeframes ▲ OHA currently oversees D-SNP contracting; providing ODHS with resources to partner with OHA on D-SNP program design and oversight could foster improved LTSS coordination with D-SNPs	▼ SMACs are due to Centers for Medicare & Medicaid Services (CMS) for approval in the July prior to the Contract Year ▼ Establishing additional requirements creates additional contract compliance burden

OPPORTUNITY: SUPPLEMENTAL BENEFITS ALIGN WITH POST-ACUTE CARE NEEDS

Medicare Advantage plans offer supplemental benefits that can help to address key barriers to hospital discharge.

Percent of Oregon D-SNP Enrollees in a D-SNP that Offers the Supplemental Benefit



Key Insights and Opportunities for Oregon:

Through the **State Medicaid Agency Contract (SMAC),** Oregon can require D-SNPs to:

- ❑ **Collaborate** with the state on supplemental benefit offering plans including those supporting community living (e.g., transportation, meals, caregiver supports).
- ❑ Provide a **designated point of contact** for beneficiaries and case managers to coordinate with Medicaid benefits.
- ❑ Provide more detailed information who would be **eligible for each supplemental benefit.**
- ❑ Report on supplemental benefit **usage or other quality metrics.**

ATI Advisory analysis of the 2024 CMS PBP database and January 2024 CPSC file.
Note: certain benefits, called SSBCI, must be targeted based on chronic condition, functional impairment, and/or income level.

CCOs HAVE FLEXIBILITY TO OFFER INNOVATIVE OR SOCIAL-NEED BENEFITS THAT CAN SUPPORT TIMELY AND APPROPRIATE HOSPITAL DISCHARGES

Flexible Services

- CCOs may optionally choose to offer select Flexible Services, for example:
  - Food supports
  - Short-term housing supports
  - Temporary housing or shelter while recovering from hospitalization
  - Cell phones or mobile devices for accessing telehealth or health apps
  - Other items that keep you healthy, such as an air conditioner or air filter
- Flexible services may be requested by an individual, their family member, provider, or a health plan case manager. However, because beneficiaries often do not know about flexible services that are available, benefits are not equitably distributed.

In Lieu of Services (ILOS)

- CCOs are permitted to offer pre-approved medically appropriate and cost-effective substitutes for covered services in the State Medicaid Plan. Example of relevant approved ILOS include:
  - Community Health Worker services
  - Peer and Qualified Mental Health Associate services

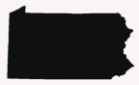
Community Investments

- The **Community Benefit Initiatives** (CBI) allows CCOs to support programs that will impact members health related social needs through their global budget.
- The **Supporting Health for all through REinvestment** (SHARE) program requires CCOs to spend on SDOH community priorities. A portion of SHARE Initiative spending must go toward housing-related services and supports.

Comparing CCO spending initiatives. Oregon Health Authority. March 2024.
Flexible Services Information for Oregon Health Plan Members in Coordinated Care Organizations. Oregon Health Authority. August 2022.

OPPORTUNITY: PARTNER WITH CCOs ON STATE GOALS TO PROMOTE TIMELY AND APPROPRIATE HOSPITAL DISCHARGES

Through its CCO model, the Oregon Health Plan has long been innovating to address members' non-medical needs. Oregon can leverage its existing CCO infrastructure to advance State goals of promoting timely and appropriate hospital discharges for populations of focus through CCO contracts and/or procurements.

State in Practice	Managed Care RFP Text	Takeaway	Oregon Considerations
Arizona 	*"Describe how the Offeror will use existing Medicaid compensable services as well as non-covered services and supports to address social risk factors impacting members. Include how the Offeror will **capture data related to Social Determinants of Health to ensure members are connected and have timely access to needed social services**."*	▪ Oregon could ask CCOs how they will address **social and medical post-acute care needs**, that impact hospital discharges including housing, meals, and personal care.	▪ Oregon is currently completing their CCO contracting for 2025-2029. Procurement documents for the next cycle will likely be released **1-1.5 years before the contracting period begins**, likely in 2028. ▪ Because Oregon CCOs are regional, **RFP responses could be locally customized** to local AAA, APD, and CBO relationships and geographic factors.
Pennsylvania 	*"Describe how you will approach nursing home transition (NHT) service delivery, **including but not limited to how you will approach NHT for populations with barriers to housing**."*		
Tennessee 	*"The Respondent shall provide a plan that outlines their community investment approach. The community investment plan shall aim to **address health outcomes through targeting members' unmet non-medical risk factors and reflect adequate, data-driven approaches**. The plan shall contain, including but not limited to, the non-medical risk factors to be addressed, population(s) of focus, and an evaluation plan."*	▪ Oregon could ask how plans will **invest in and partner with CBOs** to address individuals' barriers to a timely hospital discharge.	

AAA – Area Agency on Aging; APD – Office of Aging and People with Disabilities

CCO 2025: Contract Procurement Report. Oregon Health Authority. February 2023.

OPPORTUNITY: ENHANCED CARE MANAGEMENT TO SUPPORT TIMELY DISCHARGE

Getting connected to medical and health-related social needs services within the delivery system is a key reported barrier to timely discharge. Enhanced care management can help individuals access services and maintain health.

CalAIM's Medicaid Managed Care Programs for At-Risk Members

Enhanced Care Management (ECM)

Health plans offer eligible high-risk members (e.g., adults experiencing homeless) a **single lead care manager**.

Hospital must notify health plans/ECMs of hospitalization **within 24 hours**.

ECMs are critical in **supporting post-acute care,** including medication reconciliation and following up on referrals, physical, social, and mental health needs.

Transitional Care Services (TCS)

Health plans offer **all members** TCS to transition between settings, including hospital discharges.

The TCS care manager will **share hospital discharge information with relevant providers, facilitate follow-ups**, and refer individuals to needed services.

Community Supports (CS)

Health plans are permitted to **offer HRSN benefits**, e.g., housing supports, short-term post-hospitalization housing, respite, home modifications, day program, and medically supportive meals etc.

California supports community partners with **funding for technical assistance**.

Key Opportunities for Oregon:
✓ **In place today**
❑ **Opportunity**

- ✓ Afford CCOs flexibility to **offer HRSN benefits to target populations** through a Section 1115 Demonstration.
- ❑ Support partners and local community-based organizations with **technical assistance** to build capacity and engage with CCOs.
- ❑ Bolster transitional care case management requirements and expectations for CCOs, with focus on equipping case managers with **needed data** (e.g., ADT).

ATD – Admission, Discharge, Transfer Data; HRSN – Health Related Social Needs
Additional ECM populations of focus include but are not limited to: adults, youth, and children who are **at risk for avoidable hospital or emergency department care** and with **serious mental health and/or substance use disorder needs**; adults and youth who are **transitioning from incarceration.**

Overview of Flexibilities to Streamline and/or Promote Access to Medicaid LTSS

AGENDA

- Overview: State Flexibilities Under Consideration to Streamline Medicaid Processes for Timely Hospital Discharge
- Presumptive Medicaid Eligibility for LTSS
  - State Questions and Considerations for Policy Implementation
- Medicaid Asset Test Flexibilities
  - State Questions and Considerations for Policy Implementation
- Appendix: Detailed State Approaches to Presumptive Eligibility and Asset Test Flexibility

STATE FLEXIBILITIES TO STREAMLINE MEDICAID ENROLLMENT AND RENEWALS TO PROMOTE MORE TIMELY DISCHARGE

Likely Authority Required: Section 1115 Demonstration

Presumptive Eligibility (PE)

EXPAND PE TO LONG-TERM SERVICES AND SUPPORTS

Expand PE authority to coverage for LTSS

EXPAND PE TO NON-MAGI GROUPS

Expand PE authority from exclusively MAGI groups to include non-MAGI groups, covering those aged, blind, and disabled with Medicare

Asset Test Flexibilities

EXPAND ASSET LIMIT

Increase maximum asset limit for consideration for post-acute care coverage above the standard

ELIMINATE ASSET LIMIT

Eliminate asset test(s) from consideration for post-acute care coverage entirely

STREAMLINE ASSET TEST PROCESS

Shorten the Look-Back Period or use self-attestation in lieu of official document verification

Overview: Presumptive Eligibility for Medicaid LTSS

IMPROVING TIMELY ACCESS TO MEDICAID LTSS VIA **PRESUMPTIVE ELIGIBILITY**

→ For an individual to access Medicaid LTSS, they must complete 1) a functional assessment, 2) a financial assessment and 3) have a care plan developed. These steps may create delays in LTSS access and ultimately hospital discharge.

Term	Definition	Process	Requirements for Potential Enrollees	State Flexibility
Presumptive Eligibility (PE)	▪ PE is a Medicaid enrollment approach which authorizes certain qualified entities (e.g., healthcare providers) to screen for Medicaid and CHIP eligibility and **enroll** individuals who appear to be eligible. ▪ **Coverage is immediate and temporary** while individuals complete full applications for Medicaid. ▪ Hospital PE is standard for Modified Adjusted Gross Income (MAGI) populations but is more complicated for LTSS populations.	▪ There is no standard PE process for states. ▪ Organizations meet requirements determined by the state to become a **Qualified Entity** to assess PE. ▪ **To receive PE coverage, individuals must self-attest** to meeting standard Medicaid income and eligibility group requirements. If determined eligible, individuals may receive services for a PE period of up to 60 days and are **given a deadline to formally apply for Medicaid with full documentation** to continue receiving care.	State requirements vary, but generally, to receive PE approval, individuals self-attest to meeting **standard Medicaid income and eligibility group requirements**, including: • Being a state resident and citizen or qualified non-citizen; • Not be currently receiving Medicaid of any kind; • Not have recently been denied for Medicaid; • Have a gross household income at or below the income level for household size; and • Being a part of a categorical eligibility group. **If individuals do not formally apply or are denied Medicaid eligibility, services are discontinued at the end of the PE period and no repayment of services is required.*	As a result of the Affordable Care Act (ACA), **all state Medicaid programs are federally required to implement hospital PE for Medicaid** coverage for MAGI groups. Washington and California are examples of states that have pursued authority to expand PE to LTSS or use PE to cover new groups.

1. "Medicaid Eligibility: 2024 Income, Asset & Care Requirements for Nursing Homes & Long-Term Care." Medicaid Planning Assistance, American Council on Aging, 29 Jan. 2024, www.medicaidplanningassistance.org/medicaid-eligibility/.
2. "Spending down Assets to Become Medicaid Eligible for Nursing Home / Long Term Care." Medicaid Planning Assistance, American Council on Aging, 26 Jan. 2024, www.medicaidplanningassistance.org/medicaid-spend-down/.

STATE APPROACHES TO PRESUMPTIVE ELIGIBILITY

- Some states are exploring options to expand their PE programs to authorize new services within post-acute care and cover new eligibility groups.
- Washington and California are currently leading in PE policy innovation.

Expand PE Coverage to New Services	Expand PE Coverage to New Groups
 **Washington**. Under Section 1115 Demonstration authority, created an HPE program for regular Medicaid as well as for **long-term supports and services (LTSS)** to identify presumptively eligible beneficiaries for two of its HCBS programs, Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).	 **California.** Under Section 1115 Demonstration authority, expanded HPE program to **new "Aged" group** encompassing individuals who are ages 65 and older, not eligible for Medicare, and have an income up to 138% of the federal poverty level (FPL).

Additional detail on each state's approach is found in Appendix II

1. Office for State, Tribe, Local, and Territorial Support. "Hospital Presumptive Eligibility." *CDC*, Centers for Disease Control and Prevention, www.cdc.gov/phlp/docs/hospitalpe-brief.pdf. Accessed 19 Mar. 2024.
2. Guth, Madeline, and MaryBeth Musumeci. "State Options to Expand Medicaid HCBS: Examples & Evaluations of Section 1115 Waivers - Appendix - 9758." *KFF*, KFF, 16 July 2021, www.kff.org/report-section/state-options-to-expand-medicaid-hcbs-examples-evaluations-of-section-1115-waivers-appendix/.
3. Presumptive Eligibility for Home and Community Services (HCS)." *Washington State Health Care Authority*, Washington Health Care Authority, 4 Dec. 2023, www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/presumptive-eligibility-home-and-community-services-hcs.

- When modifying PE policy, key considerations and challenges may present:

  - Developing and submitting required requests to CMS, section 1115 demonstration applications or amendments in particular, can be very time consuming and requires additional administrative capacity.

  - Understanding what new operational processes may be required to use PE to authorize LTSS coverage.

  - Developing plans to train Qualified Entities on new processes for LTSS PE authorization that meet CMS requirements.

Overview: Medicaid Asset Test Flexibilities

IMPROVING TIMELY ACCESS TO MEDICAID LTSS VIA ASSET TEST INNOVATIONS

- Financial eligibility determinations, particularly for older adults and individuals with disabilities (i.e., non-Modified Adjusted Gross Income Medicaid eligibility groups]) are process and time-intensive, delay hospital discharge, and can impede timely access to services.
- States are pursuing authority to increase or eliminate the asset limit, shorten the look-back period, or allow for self-attestation of application information to streamline and simplify existing processes.

Term	Definition	Process	Requirements for Potential Enrollees	State Flexibility
Asset Test(s)	Asset tests are a procedure state Medicaid agencies use to determine eligibility for non-MAGI in which an individual's **countable assets are considered**. Assets become particularly important in determining coverage for post-acute care, such as LTSS. Countable assets considered may include, but are not limited to, bank accounts and cash, property (not including a home being lived in), and investments.	Medicaid agencies request documentation such as bank or retirement account statements from an applicant to **verify their countable assets**. Generally, there is a **Medicaid Look-Back Period** in which a state's Medicaid agency reviews all past asset transfers within 60 months from the date of application to determine if assets are within program limits. If not, individuals must begin **spending down assets** to become eligible for coverage.	State requirements vary, but generally, to receive Medicaid coverage for home- and community-based services (HCBS) individuals must meet the following asset limits: • $2,000 for one single applicant; • $3,000 for both married applicants; and • Up to $154,140 for one married applicant under the Community Spouse Resource Allowance (CSRA).	Asset tests are used by **state Medicaid agencies to determine eligibility for non-MAGI groups**, including those who are: • Aged (65 and older); • Blind with Medicare; and • Disabled with Medicare. **An exception to this rule exists when a Medicare beneficiary or an individual age 65 or over is a parent or caretaker relative with children under age 19.* New York, Vermont, California, New Jersey, Michigan, and Rhode Island are all examples of states that have pursued authority to increase or eliminate the asset limit, shorten the look-back period, or allow for self-attestation of application information.

1. "Medicaid Eligibility: 2024 Income, Asset & Care Requirements for Nursing Homes & Long-Term Care." Medicaid Planning Assistance, American Council on Aging, 29 Jan. 2024, www.medicaidplanningassistance.org/medicaid-eligibility/.
2. "Spending down Assets to Become Medicaid Eligible for Nursing Home / Long Term Care." Medicaid Planning Assistance, American Council on Aging, 26 Jan. 2024, www.medicaidplanningassistance.org/medicaid-spend-down/.

STATE APPROACHES TO ASSET TEST FLEXIBILITIES

- In most states, standard policies apply with a general asset limit of $2,000 for an individual applicant, and $3,000 for a couple; however, these limits may be adjusted or eliminated by way of Medicaid Section 1115 demonstration authority.
- New York, California, and New Jersey are currently leading in asset test policy innovation.

Increase Asset Limits

New York. Under Section 1115 authority, **expanded asset limits** to up to $30,182 for an individual applicant, and $40,821 for a couple applying up from $2,000 per applicant and $3,000 per couple.

Vermont. Under Section 1115 authority, **increased the asset limit to $10,000** for High and Highest Need beneficiaries who receive HCBS, but are at risk for institutionalization.

Eliminate Asset Limits

California. Under Section 1115 authority, **eliminated the asset limit** from consideration for non-MAGI Medi-Cal eligibility.

Decrease Administrative Burden

New Jersey. Under Section 1115 authority, permits those with income equal to or below 100% FPL and who need an institutional level of care to **self-attest that assets or resources have not been transferred** in lieu of the five-year look-back period.

Shorten Look-Back Period

New York. Under Section 1115 authority, look-back period for asset verification was **shortened from 60 months to 30 months** prior to application date for beneficiaries seeking coverage for HCBS.

Additional detail on each state's approach is found in Appendix II

1. Guth, Madeline, and MaryBeth Musumeci. "State Options to Expand Medicaid HCBS: Examples & Evaluations of Section 1115 Waivers - Appendix - 9758." *KFF*, KFF, 16 July 2021, www.kff.org/report-section/state-options-to-expand-medicaid-hcbs-examples-evaluations-of-section-1115-waivers-appendix/.
2. "New York State Medicaid Redesign Team (MRT) Waiver." *30-Month Lookback for Community Based Long Term Care Services: Amendment Request*, New York Department of Health, health.ny.gov/health_care/medicaid/redesign/mrt2/. Accessed 3 Apr. 2024.

- When modifying asset test policy, key considerations and challenges may present:

  - Developing and submitting required requests to CMS, section 1115 demonstration applications or amendments in particular, can be very time consuming and requires additional administrative capacity.
  - Understanding what time and training is required to modify current asset test policy.
  - Identifying data and analytic methods to determine to what extent the asset limit should be increased, or if it should be eliminated.
  - Understanding to what extent an asset limit increase or elimination may impact the new eligible population.

Appendix I: Methods and Key Definitions for Provider Payment Analysis

Oregon All-Payer All-Claims (APAC) Database

Data Description	Established in 2009, the APAC database contains administrative healthcare claims data that includes utilization and costs for Oregon's insured populations, including Commercial, Medicaid and Medicare payers. Claims data includes medical, dental, pharmacy and enrollment data.
Time Period	2017 – 2022
Analytical Methods	ATI analyzed allowed amounts for claims paid by Medicare (includes FFS and Medicare Advantage) and Commercial payers, and paid amounts for claims paid by Medicaid. Using enrollment data, Medicaid payments were categorized into FFS or CCO. Producer Price Index for Home Health agencies and nursing facilities provided by the Bureau of Labor Statistics, and CMS ESRD Market index were used to adjust reimbursed amounts to 2017 dollars.
Inclusion Criteria	ATI's analysis includes all claims from selected post-acute care providers such as skilled nursing facilities, home health services and dialysis centers in Oregon. All services rendered from these selected post-acute care providers are included.
Complex Care Patient Diagnostic Cohorts	ATI identifies and discusses findings across 6 complex care patient diagnostic cohorts: *SMI, SUD, Housing Insecurity, ADRD, Obesity,* and *Frailty.* *SMI, SUD, Housing Insecurity, ADRD*, and *Obesity* are identified through ICD10 diagnosis codes available in the APAC. *Frailty* is identified using the claims-based Kim Frailty Index where ICD10 diagnosis codes and procedures codes are used. The Kim Frailty Index is validated only to individuals older than 65 years old, and thus the definition of frailty is limited to individuals older than 65 years old.
Limitations	Subgroups of self-insured individuals are not available in the APAC. Additionally, there are biases and data limitations embedded in healthcare administrative claims. APAC should not be considered as a comprehensive picture of medical records, but as one part of the overall picture of Oregon's healthcare system. APAC does not include the uninsured population in Oregon. As of 2021, 4.6% of Oregon residents were uninsured.[1]

ESRD – End Stage Renal Disease; **SMI** – Serious Mental Illness; **SUD** – Substance Use Disorder; **ADRD** – Alzheimer's Disease and Related Dementias; **FFS** – Fee For Service; **CCO** – Coordinated Care Organization/Managed care

1. The rate of uninsured individuals in Oregon is available in Oregon Health Insurance Survey dashboard (link).

KEY TERMS AND DEFINITIONS USED IN ATI'S PAYMENT ANALYSIS USING THE APAC

Selected Post-Acute Care Providers	**Skilled Nursing Facilities**	Claims with place of service codes (31), which describe facilities that provide inpatient skilled nursing care, but not the level of care or treatment available in a hospital **and** *inpatient* identification in the APAC grouper ID; **or** claims with revenue codes (0022)
	Home Health Services	Claims with bill type codes that starts with (3xx) **and** these selected revenue codes (550, 551, 559, 571, 424, 421, 434, 431, 444, 441, 270, 271, 272).
	Dialysis Centers	Claims with bill type codes that start with (72x) **or** place of service code (65) that describes non-hospital facilities that provide dialysis treatment, or maintenance or training to patients or caregivers.
Analytical Methods	**Hospital Regions**	Hospital Regions for selected post-acute care providers are identified using the provider directory listed in the APAC which identified cities for each providers. This was then categorized into counties.
	Reimbursed Amounts	Allowed amounts for Medicare and Commercial claims are used for the analysis. For Medicaid claims, as there is no cost-sharing, the definition of “allowed” amounts are not comparable to other payers. Based on Oregon Health Authority’s recommendation, paid amounts are used for Medicaid claims only.
	Episodes of Care	Episodes of care for claims from skilled nursing facilities and dialysis centers are defined by length of days between service start day and end date as indicated in each adjudicated claim. Reimbursed amounts are defined as “per diem” for skilled nursing facilities and dialysis centers. Episode of cares for claims from home health services are defined using reported service quantities where reimbursed amounts are defined as “per service rendered”.
	Adjusted Amounts	All dollars are reported in 2017 dollars for the analysis, adjusted using producer price index or ESRD market index. Note that for home health services, changes in reimbursed rates are compared between 2020 and 2022, due to CMS’ new Patient-Driven Grouping Model (PDPM) implemented in 2020.

KEY TERMS AND DEFINITIONS USED IN ATI'S APAC ANALYSIS

Complex Care Diagnoses

Serious Mental Illness (SMI)	Diagnosis indicated anywhere in Medicare, Medicaid, or Commercial medical claims.
Substance Use Disorder (SUD)	Diagnosis indicated anywhere in Medicare, Medicaid, or Commercial medical claims.
Housing Insecurity	Diagnosis indicated anywhere in Medicare, Medicaid, or Commercial medical claims. Housing insecurity definitions widely vary and no standardized measure exists. ATI's study relied on imperfect and underutilized *ICD-10* Z59-codes that are likely to capture the most extreme experience of housing insecurity: homelessness. Despite these limitations, *ICD-10* Z-codes remain an important metric for identifying nonmedical factors that may influence an individual's health status.
Frailty	Kim Frailty Index, which uses diagnoses and procedures available in medical claims. The Kim Frailty Index has only been validated for individuals 65 years and older. Thus, the application of the Kim Frailty Index is limited to individuals 65 years and older. Individuals who are identified as "moderately" or "severely" frail from the Kim Frailty Index are identified as *frail* as indicated by having a Kim Frailty score greater or equal to 0.35.
Alzheimer's Disease and Related Dementias (ADRD)	Diagnosis indicated anywhere in Medicare, Medicaid, or Commercial medical claims.
Obesity	Diagnosis indicated anywhere in Medicare, Medicaid, or Commercial medical claims.

SKILLED NURSING FACILITIES REIMBRUSEMENT RATES INCREASED ACROSS PAYERS AND REGIONS/ REGIONAL AND PAYER VARIATION EXISTED IN HOME HEALTH AND DIALYSIS CENTER REIMBURSEMENT

Region	Skilled Nursing Facilities			Home Health			Dialysis Centers		
	Changes from 2017 to 2022			Changes from 2020 to 2022*			Changes from 2017 to 2022		
	Medicaid	Medicare	Commercial	Medicaid	Medicare	Commercial	Medicaid	Medicare	Commercial
Statewide	▲ ***Increased by 46%***	▲ ***Increased by 34%***	▲ ***Increased by 14%***	▼ ***Decreased by 9%***	▲ ***Increased by 0%***	▲ ***Increased by 18%***	▼ ***Decreased by 37%***	▲ ***Increased by 8%***	▼ ***Decreased by 10%***
Region 1	▲ Increased by 40%	▲ Increased by 9%	▲ Increased by 1%	▼ Decreased by 15%	▲ Increased by 17%	▲ Increased by 23%	▼ Decreased by 54%	▼ Decreased by 10%	▼ Decreased by 20%
Region 2	▲ Increased by 50%	▲ Increased by 48%	▲ Increased by 35%	▲ Increased by 4%	▼ Decreased by 16%	*Not reported due to insufficient sample size*	▲ Increased by 21%	▲ Increased by 37%	▼ Decreased by 2%
Region 3	▲ Increased by 45%	▲ Increased by 23%		▲ Increased by 8%	▼ Decreased by 25%	▲ Increased by 0%	▲ Increased by 8%	▲ Increased by 75%	*Not reported due to insufficient sample size*
Region 5	▲ Increased by 39%	▲ Increased by 71%		▼ Decreased by 8%	▼ Decreased by 6%	▲ Increased by 3%	▲ Increased by 71%	*Not reported due to insufficient sample size*	
Region 6	*Not reported due to insufficient sample size*	▲ Increased by 5%	*Not reported due to insufficient sample size*	*Not reported due to insufficient sample size*			*Not reported due to insufficient sample size*		
Region 7	▲ Increased by 73%	▲ Increased by 14%		▼ Decreased by 7%	▼ Decreased by 1%	▲ Increased by 22%	▲ Increased by 33%	*Not reported due to insufficient sample size*	
Region 9	▲ Increased by 57%	▲ Increased by 18%		▲ Increased by 9%	*Not reported due to insufficient sample size*		▲ Increased by 42%	*Not reported due to insufficient sample size*	

Skilled Nursing Facilities: Producer Price Index for Nursing Facilities for each payer from Bureau of Labor Statistics was used to adjust to 2017 dollars. **Home Health:** Medicare payments for Home Health changed to Patient-Driven Grouping Models, which includes shorten claims duration from 60 days to 30 days, as of January 2020. Producer Price Index for Home Health agencies for each payer from Bureau of Labor Statistics was used to adjust to 2017 dollars **Dialysis Centers**: CMS ESRD Index levels was used to adjust to 2017 dollars for all payers. *For Home health, Medicare enacted a new PDGM model in 2020, thus ATI compared 2020 and 2022. **Source:** ATI analysis of Oregon All-Payer All-Claims data, 2017-2022; 0% represents < |0.4%|. Sample size less than 50 are not reported; Medicaid includes both CCO and FFS.

Appendix II: Detailed State Approaches to Presumptive Eligibility and Asset Test Flexibility

STATES ARE EXPLORING OPTIONS TO EXPAND THEIR PE PROGRAMS TO AUTHORIZE NEW SERVICES WITHIN PAC AND COVER NEW ELIGIBILITY GROUPS

State	Policy	Authority	Process
 **Washington (Approved)**	Created hospital PE program for regular Medicaid as well as for **LTSS** to identify presumptively eligible beneficiaries for two of its HCBS programs, Medicaid Alternative Care (MAC) and Tailored Supports for Older Adults (TSOA).	State submitted **Medicaid State Plan Amendment (SPA) and 1915(c) HCBS waiver** authorities to gain approval from CMS to enact policy	• Similar to the state's hospital PE process, LTSS PE authorizes LTSS based on a brief screening of financial and/or functional eligibility criteria determined by a Qualified Entity, a WA Home and Community Services (HCS) staff member • Those under PE may receive WA Medicaid categorically needy (CN) coverage for up to 60 days while eligibility is being determined • If the recipient does not file a formal Medicaid application within 10 days after LTSS PE determination, the PE period stops at the end of the month following the month services were first authorized • Individuals may not be determined eligible for PE for more than one period in a twelve-month period
 **California (Approved)**	Expanded hospital PE program to **new "Aged" group** encompassing individuals who are ages 65 and older, not eligible for Medicare, and have an income up to 138% of the federal poverty level (FPL).	State used **Section 1115 Demonstration** authority to gain approval from CMS to enact policy State implemented hospital PE program under Welfare and Institutions Code Section 14011.66, as prescribed in Senate Bill X1 1, Chapter 4, Statutes of 2013	• Hospital PE is authorized based on a brief screening of financial and/or functional eligibility criteria determined by a Qualified Entity, a trained staff member at a participating hospital • Individuals in the "Aged" group undergo the same determination process as individuals among traditional eligibility groups
 **New Hampshire (Pending)**	Requested to build on existing PE processes and infrastructure to **expand the state PE program to LTSS identify presumptively eligible beneficiaries for HCBS** on or before 9/30/24	State required to use **Section 1115 Demonstration** authority to gain approval from CMS to enact policy	• Individuals apply for HCBS under the NH Department of Health and Human Services' 1915(c) HCBS waiver • Available statewide to individuals ages 18 and older who qualify for an eligibility group approved in the 1915(c) Choices for Independence (CFI) HCBS Waiver • Coverage is determined by a Qualified Entity and will cover the most appropriate and least restrictive care setting for up to 30 days while full functional and/or financial eligibility are determined • Individuals may not be determined eligible for PE for more than one period in a twelve-month period • All participants in HCBS PE are subject to Medicaid estate recovery requirements

1. "New Hampshire Department of Health and Human Services Substance Use Disorder Serious Mental Illness Serious Emotional Disturbance Treatment and Recovery Access Section 1115(a) Research and Demonstration Waiver." *Medicaid.Gov*, Center for Medicaid and CHIP Services , 28 Mar. 2024, www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-sud-treatment-recovery-access-pa.pdf.
2. "Presumptive Eligibility for Home and Community Services (HCS)." *Presumptive Eligibility for Home and Community Services (HCS) | Washington State Health Care Authority*, Washington Health Care Authority, 4 Dec. 2023, www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/presumptive-eligibility-home-and-community-services-hcs.
3. "Hospital Presumptive Eligibility Program." *DHCS*, State of California, www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/HospitalPE.aspx. Accessed 16 Apr. 2024.

SUMMARY OF DIFFERING STATE APPROACHES TO ASSET TEST INNOVATION

State	Policy	Authority
 California	**Eliminated the asset limit** from consideration for Medi-Cal eligibility for non-MAGI groups Under SPA CA-21-0053, increased the asset limit to the maximum $130,000 and uses expenditure authority to cover individuals over the limit using overall budget neutrality savings from current state Section 1115 Demonstration to effectively remove the asset limit.	State used **State Plan Amendment** authority to gain approval from CMS to enact policy
 New York	**Increased the asset limit** to up to $31,175 for an individual applicant and $42,231 for a couple applying, up from the general $2,000 per applicant and $3,000 per couple **Shortening the look-back period for asset verification from 60 months to 30 months** prior to application date for beneficiaries seeking coverage for HCBS. The “look back” will be 30 months instead of 60 months as it is for Institutional Medicaid sometime in 2025.	State used **Section 1115 Demonstration** authority to gain approval from CMS to enact policy
 Vermont	**Increased the asset limit** to $10,000 for High and Highest Need beneficiaries in the state’s Choices for Care (CFC) program who own and reside in their own homes and who opt to receive HCBS in lieu of institutional services	State used **Section 1115 Demonstration** authority to gain approval from CMS to enact policy
 New Jersey	Allowed those with income equal to or below 100% FPL and who need an institutional level of care to **self-attest that assets or resources have not been transferred in lieu of the five-year look-back period**	State used **Section 1115 Demonstration** authority to gain approval from CMS to enact policy

1. “Asset Limit Changes for Non-MAGI Medi-Cal Eligibility and Enrollment Plan.” *DHCS*, State of California, 17 Feb. 2023, www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Eligibility-and-Enrollment-Plan-Asset-Test-Changes-for-Non-MAGI-MC.pdf.
2. “Department of Health.” *Medicaid Redesign Team (MRT) II*, New York State, Sept. 2022, www.health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_lookback-final.htm.
3. “New York Medicaid Eligibility for Long Term Care: Income & Asset Limits.” *Medicaid Planning Assistance*, American Council on Aging, 7 Mar. 2024, www.medicaidplanningassistance.org/medicaid-eligibility-new-york/.
4. “Vermont Global Committment to Health Renewal.” *Medicaid.Gov*, Centers for Medicare and Medicaid Services, 22 Mar. 2024, www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/vt-global-commitment-to-health-pa4.pdf.
5. “New Jersey Family Care Comprehensive Demonstration.” *Medicare.Gov*, Centers for Medicare and Medicaid Services, 29 Nov. 2023, www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-1115-ext-req-pa.pdf.