Meeting Summary

Joint Task Force on Hospital Discharge Challenges
Meeting #9
Link to Task Force on OLIS

LPRO
LEGISLATIVE POLICY AND RESEARCH OFFICE

Date/Time	June 27, 2024, 9-1pm (link to recording)
Attendees	Chair Jimmy Jones Vice Chair Elizabeth Burns Daniel Davis Jeff Davis Trilby de Jung Eve Gray Felisa Hagins Alice Longley Miller Raymond Moreno Rachel Currans Henry Jane-ellen Weidanz Phil Bentley Representative Christine Goodwin Kathy Levee Excused: Jonathan Weedman Sarah Ray Joe Ness Leah Mitchell Sen. Deb Patterson Jesse Kennedy Jonathan Eames
Opening Remarks and Meeting Overview (slides)	Today's meeting will focus on coverage and reimbursement for long-term services and supports, including: 1) Reimbursement for LTSS including adult foster homes; 2) Promoting timely hospital discharge through managed care authorities; 3) Analysis of the Oregon Health Plan post-hospital extended care benefit; and 4) State flexibilities to streamline access to LTSS. Today's meeting is the last of four "focused conversations" bringing in-depth policy and data analysis and expertise to help inform Task Force deliberations in specific policy areas. At the July meeting, ATI will provide a recap and synthesis of key findings across these analyses, as well as providing additional information about medical respite programs and a straw proposal for a hospital discharge escalation protocol. Beginning in July, meetings will shift to focus on member discussion and consideration of possible recommendations. After today's meeting, staff will share a "policy tracker" – a list of concepts that members have expressed interest in – for members to review and discuss with their constituencies in preparation for the July meeting. The tracker organizes potential concepts into six areas that

correspond to the framework for policy recommendations outlined in House Bill 3396.

In July, members will have the opportunity to discuss policy concepts, flagging priority concepts as well as concepts that should not move forward. Staff will work with the chair, vice chair, and ATI Advisory consultants to prepare a first draft of recommendations from members' input. Draft recommendations will be shared for discussion and iteration at the September meeting.

Staff will update draft recommendations following member feedback and prepare a draft report for Task Force review at the October meeting. Staff will incorporate further member feedback on the final recommendations and report that will be presented for task Force approval at the November meeting.

Members are encouraged to reach out to the chair, vice chair, or staff, with any questions or feedback between meetings.

Overview of Medicaid Payment for LTSS and Post-Pandemic Trends Impacting Payment (slides 1-9 and appendix)

ATI Advisory

- Cleo Kordomenos
- Kristen Lunde

ATI Advisory provided an overview of the role of Medicare and Medicaid in paying for long-term services and supports. Key points covered include:

- Medicare generally *does not* pay for long-term care. It does offer reimbursement for skilled nursing facility care, only after a hospitalization, and limited for up to 100 days per spell of illness.
- Medicare also pays for home health care for individuals who are homebound or need intermittent or part-time services. This can include therapy (physical, occupational, speech) or home health care aides, though these visits are extremely rare under Medicare coverage. This benefit does not play much of a role in post-acute care for people with complex or longer term needs.
- Medicaid is the primary third-party payer for LTSS, in addition to other limited public programs. Many people pay for LTSS out of pocket or receive unpaid care from others such as family. There are significant unmet needs for LTSS among people who go without sufficient formal or informal long term care.

Nationally, LTSS are used by a range of individuals, the majority of whom (55%) are older or physically disabled. Other groups include people with developmental disabilities (25%), behavioral health needs (7%) or who fall in more than one of these groups (13%). Spending on LTSS for these populations varies across states and settings. The federal government requires states to cover nursing facility care; coverage of home and community-based care is optional. Nationally, Oregon spends the highest share of Medicaid LTSS dollars on home and community-based care (83.3%).

ATI noted that looking ahead, state Medicaid agencies are navigating significant uncertainty in the federal policy and payment landscape. The pandemic exacerbated existing workforce challenges in HCBS; states used time-limited pandemic funding to make significant investments in this workforce and now face challenges sustaining those enhancements. New federal Medicaid payment rules effective April 2024 impose requirements regarding rates and percent of payments that must go toward compensation of workers. The impact of these changes is not yet known.

Update on ODHS Rate and Wage Study (slides)

Burns and Associates: Stephen Powlowski

Burns and Associates are health policy consultants contracted with ODHS to develop provider rates and provide other services. They provided an overview of APD rates and payment methodologies for **home and community-based providers, including adult foster homes (AFH), residential care facilities (RCF), and assisted living facilities (ALF)**. Oregon's current methodology for AFH and RCF is different than the methodology for ALF. All three approaches are described further below.

Current and Historic APD Payments

Adult Foster Home (AFH) rate methodology. AFHs may care for up to five individuals. Under the state's current methodology, the base rate of $2,029 per month covers a 1:5 staffing ratio.

- The base rate may be augmented by up to three 'add-ons' for $369 per month for: 1) full assistance in mobility, eating, or elimination; 2) behavior that poses a risk to the individual or others; and/or 3) medical treatments that require oversight by a licensed healthcare professional. Rate exceptions may be approved to cover additional staff needed.
- Special needs contracts are available that pay higher rates to support individuals with specified needs such as brain injury, cognitive/memory care, ventilator dependence, or behavioral needs. Special needs contracts range from $4,665-23,647 per month.

Residential Care Facility (RCF) rate methodology. RCFs are buildings or a complex with living units (shared or individual) that provide care for six or more individuals.

- The payment methodology is very similar to AFHs but with slightly higher rates. Under the state's current methodology, the base rate is $2,279 per month and may be augmented by up to three add-ons for $443 per month.
- Memory care endorsed facilities receive a monthly rate of $5,977. Rate exceptions may be approved for additional staff.

Assisted Living Facility (ALF) rate methodology. ALFs are similar to RCFs but provide care to six or more individuals in *fully self-contained* living units with individual kitchen and bathroom spaces.

- The payment methodology for ALF differs from AFH and RCF. There are five rate tiers based on the level and type of support an individual needs. Rates range from $1,830 to 4,298 per month.
- Memory care endorsed facilities receive $5,977 per month.

Across APD, all services have received rate increases in the past five years. These increases differ across provider types: 36% for AFHs; 61% for ALF/RCFs; 66% for nursing facilities (NF); and 38% for developmental disability service providers. Burns cautioned comparing rate increases across provider types requires an assumption that initial rates for providers were reasonable or

appropriate relative to those providers' costs. Changes in rates over time do speak to the appropriateness of the rates themselves.

Study of Rates and Wages

It has been more than 20 years since Oregon conducted a comprehensive review of payment rates for APD services. It is no longer possible to identify what costs (such as what wage levels) are assumed to be covered by the current rates the state collectively bargains.

Through a budget note in SB 5506, the legislative assembly directed ODHS to "conduct a comprehensive rate and wage study across home and community-based service delivery systems." A written report is due to the legislature by September 2024.

Burns and Associates are contracted with ODHS to conduct the rate study. They provided an update on its in progress. Key points include:

- The goal of the study is to ensure that payment rates reflect service requirements in the Oregon context (recognizing that some provider types, such as adult foster homes, operate under different service models or scope of practice in other states).
- The current study will evaluate required qualifications, wages, and benefits for direct care workers across programs, as well as acuity of service recipients. The analysis will also explore differences in compensation policies, staff qualifications, and methods for assessing the acuity of service recipients.
- As part of the study, Burns and Associates meet with an advisory group to discuss system-level issues, as well as workgroups focused on provider-specific feedback. The study has included site visits, surveys from 200+ providers, and review of other administrative data and published literature.
- Recommendations will address opportunities to standardize across systems, services, and delivery models, with consideration of geography, participant acuity and other factors. They will consider accountability and sustainability of the payment models going forward. There will be a public comment period before recommendations are finalized.

Early insights from the rate and wage study include:

- Wages for direct care workers in Oregon are the second highest in the country, roughly 20% higher than the national average, according to BLS data (Oregon also has a higher than average cost of living).
- ODDS providers are generally paying $1-2 more per hour than APD providers ($20-21 per hour for ODDS compared to $18-19 per hour for APD). Across services, wages are highest for in-home care workers.
- Few providers are paying wage differentials, such as offering higher wages for more complex or higher acuity patients. Some providers pay higher wages for overnight and weekend shifts.

Payment Opportunities to Support Adult Foster Home Capacity for Complex Care Delivery (slides 10-14)

ATI Advisory:

- Cleo Kordomenos
- Kristen Lunde

ATI Advisory shared findings from across their analyses to date that relate to reimbursements for **adult foster homes**. Key points included:

- AFHs surveyed by ATI in March 2024 reported the fewest barriers accepting individuals with complex needs, including homelessness or housing insecurity. Interviews also consistently revealed that AFHs are most readily willing to accept individuals with complex needs from hospitals.
- However, current capacity is limited due to workforce challenges and insufficient reimbursements. 63% of AFHs disagreed or strongly disagreed that payments sufficiently cover care for people with complex needs.

AFHs are separately licensed to serve three populations. Rates vary across these licensure types in 2024:

- Foster homes for older adults and people with physical disabilities: 2,029-3,136 per month, on average,
- Behavioral health foster homes: $2,738;
- Foster homes for people with intellectual and developmental disabilities: $3,500-5,500 (as high as $9,000 for exceptional needs contracts).
- Each facility also receives a $733 room and board payment. AFH rates are negotiated through collective bargaining with SEIU 503.

ATI reviewed Washington State's acuity-based payment approach for AFHs as an example of how states can support AFH capacity to treat patients with complex needs. The Washington approach is based on 17 unique rate tiers that reflect different levels of care needed. State case managers evaluate clients using an assessment tool to determine the care needed. The assessment considers cognitive issues, complex medical conditions, moods and behaviors, and ability to engage in activities of daily living (ADL). Additional daily payment increases are available for expanded community services, specialized behavior support, community integration, HIV/AIDS treatment, and meaningful day, at all rate tiers.

Rates are negotiated between Washington State and a union, and in 2024 range from $3,400 to $6,293 per month. Washington's legislature fully funded the AFH bargaining agreement in 2023, with a 29% increase in the base payment.

Oregon's current bargaining agreement with AFHs ends in June 2025. A bill was introduced but not passed in the 2023 legislative session to in crease AFH rates and provide add-on payments.

Analysis of Reimbursement Trends to Select Post-Acute Care Providers

(slides 15-20)

ATI Advisory:

Cleo Kordomenos

ATI Advisory completed a supplemental analysis of rates for post-acute providers not covered by the ODHS rate and wage study described above. These providers primarily provide **post-acute medical care including skilled nursing facilities (SNF), home health agencies (HHA), and dialysis services**, for whom Medicare is the primary payer.

This analysis sought to understand whether and how payment issues may relate to hospital discharge challenges. Key findings from their analysis include:

- These providers have largely recovered from pandemic disruption. Service volumes rebounded from 2020-2021 lows, and providers resumed normal financial operations following federal relief funds during the public health emergency.
- Labor cost inflation continues to outpace Medicare and Medicaid reimbursement increases for many providers. A new federal minimum staffing mandate for nursing homes is also creating substantial uncertainty. Oregon already has some of the highest staffing minimums in the U.S., but this change may still impact many Oregon NFs.
- Between 2017-2022, SNF rates increased across all payers. For HHAs and dialysis centers, Medicare rates were flat or rose slightly, while Medicaid rates declined. Trends were consistent across regions and patient subpopulations.
- Overall, it is not clear that reimbursement changes are directly driving discharge challenges to these provider types. It is likely that reimbursement rates are not keeping pace with labor cost inflation, constraining post-acute providers' ability to hire more staff.

Discussion

Facilitated by Chair Jones

Chair Jones facilitated a member discussion of these payment analyses.

Sarah Ray commented that during the last AFH collective bargaining process, the union surveyed providers and 750 AFH planned to close if there was not a significant increase in rates following the 2025 bargaining process. The feedback was that the three add-on payments are not adequate to provide care for more complex individuals. This care can require providers to be present in their home 24 hours per day depending on client needs. If providers hire a respite provider so they can take a day away from work, this can cost a fifth of their monthly reimbursement. These providers can shift to other jobs that pay similar wages for less demanding or more flexible work schedules.

Providers are also concerned that the state shifting to case managers using the Oregon Needs Assessment (ONA) tool to assess client needs for developmental disability services could result in reduced payments.

Vice Chair Burns asked if ATI's analysis of barriers to entry into adult foster homes or other community-based providers also looked at the regulatory environment and how this may impact placement of patients. If AFHs increase acceptance of higher acuity patients, do we anticipate a change in the regulatory pressure and survey environment for these providers?

- ATI noted that regulatory pressures were described in interviews with both institutional and community-based providers, but more so by institutional (SNF) providers. They can follow up with additional details from their provider survey regarding how AFH providers described regulatory pressures.

Ray Moreno asked whether the design of AFH payments with optional add-ons and exception rate processes creates too much complexity? Is the Washington example shared by ATI an administratively easier process?

- ATI responded that the acuity-based payment model example from Washington may offer a simpler process for providers because it is more predictable. The Washington model also offers exceptions, so that complexity can still exist in that model, but the assessment process more transparently and consistently ties needs groupings to reimbursement levels.
- Jane-ellen noted the current APD payment is not actually very complex, in that there are only three add-ons available regardless of the number of additional needs a client may present. This is part of the problem though, in that the payment methodology cannot account for higher acuity or complexity without providers needing to request an exception rate.
- Jane-ellen also flagged that under the current payment methodology, additional staff support is allocated in 15-minute increments. This does not align to the reality of how most providers must hire additional staffing. This is why APD is working with Burns and Associates to develop an acuity-based payment model.
- Phil agreed with Jane-ellen's point and noted that the current payment approach is effectively capitated and doesn't reflect that as client acuity rises, the staffing needs to care for them also rise. Regardless of the acuity of the individual, the base payment is mostly fixed. This is also true for nursing facilities, RCF and ALF. Specific needs contracts allow for more individualized payment levels tailored to needs but not all providers will pursue this.
- Rachel noted that what seems to be helpful is to have a standardized assessment process that consistently matches client needs to certain rate tiers in a transparent way. One of Oregon's bottlenecks is that the current methodology requires APD to review case-by-case exception requests. The team do a good job of this given the complexity and limitations of this approach, but there is an opportunity to standardize the payment model so there is transparency about what payment providers can expect for a client of a given acuity level.
- Jeff Davis commented that Medicaid competes for AFH placements with private-pay and commercially insured individuals. Addressing Medicaid reimbursements for AFHs would help balance that pressure on providers across payers.

Eve Gray noted that the cost of real estate is also a barrier to new AFH providers entering the market. They have been working with a local affordable housing developer that uses a land trust model. She is curious to understand other financing models that could support or offset these costs for residential providers.

- Jane-ellen noted that in the 1990's, Oregon Housing and Community Services offered very low interest micro-loans to adult foster homes. This may be a model to look at.
- Rachel agreed and would like to explore opportunities to use housing initiatives and housing development channels to bolster the adult foster home provider network.
- Sarah noted in her area in eastern Oregon, the economic development officers will work with adult foster homes on small business plans. If there was interest in low interest or microlending programs for AFHs, county economic

development offices or small business programs may be able to help administer these programs.
- Jeff Davis also supports this concept, both to support the launch of new adult foster homes by offsetting real state costs, and providing coaching and support for people who do not have experience running a small business.

Representative Goodwin appreciated the overview of the rate variability. She asked if the state has analysis on where there are foster home shortages regionally, and also whether the current system is too onerous for providers. Chair Jones echoed this point and noted a concern that the system will not be able to meet the projected increase in demand in the coming years without changes.

- Sarah responded that there are currently more than enough IDD foster homes, to the point that there is a freeze on this licensure type in the metro area. The state is severely lacking in behavioral health foster homes and could also use additional APD foster homes. This is because rates for IDD providers are higher than for BH or APD foster homes.
- Sarah also noted with respect to the regulatory burden on providers, the state may need more licensure staff to support these processes.
- Jane-ellen commented that APD has done a gap analysis of foster homes by region and can share this information. APD is currently using ARPA funding to conduct targeted recruitment in certain underserved areas.

Jeff Davis appreciated the point from the presentations that AFH providers are currently the most able or willing to accept complex patients. This is important not only for addressing the hospital discharge issue, but also preventing avoidable readmissions to the hospital. AFH providers, because of their close relationship to clients, may be best able to identify early warning signs and intervene to help prevent avoidable readmissions.

- Daniel Davis agreed and underscored that there are many times when an AFH is the right placement setting for an individual, but the payer source (Medicaid) is the barrier to discharging and placing people quickly. They do not see the same challenges placing private-pay or LTC-insured clients in AFHs. They often hear that providers have open beds but are holding them for private pay or LTC-insured clients.

Promoting Timely Discharges through Managed Medicare and Medicaid Authorities (slides 21-30)

ATI Advisory:

ATI Advisory presented an overview of how the state can partner with managed care entities to promote timely and appropriate hospital discharges.

Oregon's managed care landscape includes:

- 15 Coordinated Care Organizations (CCOs) providing Medicaid coverage to approximately 1.2 million Medicaid beneficiaries;
- 7 Dual-Eligible Special Needs Plans (D-SNPs) providing Medicare-Medicaid coverage to 170,000 "dual eligible" beneficiaries;
- Medicaid long-term services and supports (LTSS) funded directly by ODHS and OHA. CCOs have memoranda of understanding with Area Agencies on

Cleo Kordomenos — Aging to coordinate local delivery of LTSS, but LTSS are otherwise carved out from CCO global budgets.

ATI underscored the importance of the dual-eligible population for the hospital discharge issues the Task Force is studying. Dual-eligible individuals use hospitals and LTSS at high rates, have the longest average length of hospital stay in Oregon, and often have limited resources.

Oregon has three primary levers to influence how health plans, including CCOs and D-SNPs, address post-acute care and hospital discharge:

- **D-SNP contracts.** The state has significant existing authority to influence the care dual-eligible individuals receive through its State Medicaid Agency Contract (SMAC) with D-SNPs, a type of Medicare Advantage plan for dual-eligible individuals. CMS affords states great flexibility to influence how D-SNPs operate including advancing specific models of care or use of reporting and accountability metrics. Some states are using this authority to work with D-SNPs to coordinate care for dual-eligible individuals with complex needs.
- **CCO contracts.** Oregon can use its existing managed care contracts to work with CCOs on improving care coordination or other areas that have potential to impact hospital discharge processes for Medicaid-only enrollees.
- **Managed care procurement.** Oregon can use its Request for Proposal (RFP) process for prospective CCOs to address issues related to hospital discharge and care transitions.

CCO Procurement Process

The upcoming RFP for coordinated care organizations presents an opportunity for Oregon to establish expectations early in the procurement process, as well as evaluating CCOs on the strength of their responses to new requirements. For example, the state could ask during this process how CCOs plan to address transitions of care for people experiencing homelessness or severe behavioral health conditions. States using this authority must consider how they will ensure fair evaluation of all questions and responses across CCOs, and how they will ensure oversight of any new contractual requirements.

D-SNP Contracts

Oregon can use its existing authority to influence how D-SNPs provide care to dual eligible individuals. This is a much more streamlined process than what is involved in modifying CCO contracts. D-SNP contracts are overseen by Oregon Health Authority, and are due to CMS for approval in July; states can amend these contracts annually (in some cases, more frequently). OHA could partner with ODHS on D-SNP program design and oversight to improve how D-SNP enrollees access LTSS. More robust program design changes can take anywhere from 2-12 months to work with stakeholders on changes to contracts.

Medicare Advantage plans allow for supplemental benefits, such as meals, non-medical transportation, and general supports for living (rent or utility assistance) that can help address key barriers to hospital discharge. In Oregon, very few D-SNP enrollees currently have access to supplemental benefits such as non-medical transportation or general supports for living (e.g., rent or utility assistance).

Through its D-SNP contracts, Oregon can use existing authority to:

- require D-SNPs to collaborate with the state to offer supplemental benefits;

- provide information about who would be eligible for each supplemental benefit;
- provide a designated point of contact for beneficiaries and case managers to coordinate on Medicaid benefits; and/or
- report on use of supplemental benefits as well as related quality measures.

Because Medicaid is the payer of last resort, there can be an advantage to states in leveraging these D-SNP supplemental benefits with Medicare Advantage plans for dual-eligible individuals before accessing Medicaid-paid benefits.

Oregon could require D-SNPs to offer supplemental benefits or have a designated point of contact for local coordination of benefits, similar to the current requirement that CCOs coordinate with Area Agencies on Aging for LTSS beneficiaries.

CCO Social Needs Benefits

ATI reviewed some of the existing work CCOs are doing to address social needs and how these benefits can support appropriate hospital discharges.

- **Flexible services.** CCOs have existing discretion to offer flexible services (e.g. Health Related Services) such as food support, short-term or temporary housing assistance, etc. Members are often unaware of these benefits.
- **In Lieu Of Services (ILOS).** CCOs are permitted to offer certain pre-approved services (such as Community Health Worker or Qualified Mental Health Associate services) when these are medically appropriate substitutes for traditional OHP covered services.
- **Community investments.** CCOs can use community benefit initiatives to support community programs addressing social needs. CCOs can also use their required SHARE program investments to address housing-related services that address hospital discharge challenges.

In its CCO procurement process, Oregon could strengthen how existing social needs initiatives address hospital discharge challenges, such as by:

- Asking CCOs how they will address social and medical post-acute care needs that impact hospital discharges;
- Asking CCOs how they will invest in and partner with community-based organizations to address individuals' barriers to timely hospital discharge.

Member Discussion

Vice Chair Burns facilitated member discussion of this content.

Felisa Hagins asked how supplemental payments for home modifications can be covered in existing managed care plans? Do CCO contracts currently require or allow CCOs to provide these services to individuals?

- ATI Advisory clarified that D-SNPs can cover home modifications as a supplemental benefit for dual-eligible beneficiaries. This is not being done in Oregon, but some states do require this of D-SNPs.
- Trilby de Jung noted that CCOs are not required to provide home modification services because they are covered under Medicaid LTSS. Some CCO benefit options like ILOS or Health Related Services (HRS) could be used to pay for home modifications for people who are not LTSS-eligible. OHA will follow up

with more specific information about how social needs benefit options can cover home modification services, and how many CCOs are doing this.
- Jane-ellen underscored Trilby's point that LTSS does cover home modifications, home delivered meals, etc.

Felisa asked whether CCOs and D-SNPs are required to help connect people with other services for which they are eligible, such as supportive housing, SNAP, etc.

- ATI Advisory noted CMS does not require that D-SNPs coordinate benefits in that way. However, some states are requiring D-SNPs to help in this way, particularly during the Medicaid redeterminations process. Oregon could require this.

Felisa commented that it should be a priority to use the state's existing managed care authority to promote access to home modification supports to help address this hospital discharge challenge, both for home owners and for renters.

Felisa also suggested the state should encourage or require CCOs to help with enrollment in other supports such as Supplemental Security Income (SSI), housing supports or SNAP, when this is delaying hospital discharge. Until the state reaches an adequate housing supply and shelter capacity, housing insecure people will continue discharging to the street at high levels. In the immediate term there need to be wraparound supports to connect people to other services for which they are eligible.

Analysis of Post-Hospital Extended Care Benefit (slides)

OHA: William Clark-Shim

In January 2024, the Task Force expressed interest in extending the OHP post-hospital extended care (PHEC) benefit for skilled nursing stays. Will Clark-Shim, OHA's chief actuary, presented an analysis of how this change could impact costs to the state and the Oregon Health Plan.

PHEC Benefit Analysis (Medicaid enrollees)

The PHEC benefit, which is provided through OHP medical coverage, covers nursing facility stays following a 3+ day inpatient hospital stay. The benefit applies to enrollees under age 65 who only have Medicaid coverage and are not dually covered by Medicare.

The PHEC benefit is capped at 20 days of skilled nursing care. The benefit is distinct from coverage for long-term nursing facility stays that are paid through Medicaid LTSS, which have a separate eligibility determination process. Medicaid beneficiaries can experience a coverage gap for nursing facility care if they exhaust their 20-day PHEC coverage before LTSS eligibility has been determined, since LTSS determinations can take up to 45 days. Members have identified that this coverage gap can result in denial of placement in NFs for people who do not yet have LTSS eligibility.

To understand how an extension of the PHEC benefit would impact Oregon Health Plan enrollees, OHA reviewed Medicaid claims to understand **current utilization of the PHEC benefit**. Key takeaways include:

- Between July 1, 2022 and June 30, 2023, there were 157 skilled nursing stays reimbursed under PHEC coverage. These were roughly split between CCO members (70 stays) and members enrolled in OHP fee-for-service (FFS) coverage (89 stays).

- To develop a more inclusive estimate of potential fiscal impact, the analysis also captured 1) 18 swing bed stays and 2) PHEC claims for which there was no identified associated hospital stay (13.7% of claims).
- The total annual cost of this benefit was $1.6 million, capturing nursing facility charges of $617 per person per day. The analysis does not consider other non-facility Medicaid charges (averaging $245 per person per day for, e.g., prescriptions, primary care visits, ambulance transportation) since the focus is on the PHEC benefit specifically.
- Under the current PHEC coverage model, patients admitted to nursing facilities discharge gradually between days 1-20, with about half discharging at days 19, 20, or 21.

OHA estimated the cost of extending the PHEC benefit to 30, 60, or 100 days, by modeling the cost if patients continued to discharge at a more gradual rate past day 20. Key **inputs for cost estimates** include:

- OHA noted that when the PHEC benefit ended, about 45% of this population **transition to LTSS coverage**. Among those who transitioned immediately (within 1 day) from PHEC coverage to LTSS coverage, most remained in a nursing facility. A smaller number transitioned to in-home care, with the gap between PHEC and LTSS coverage most often more than 80 days. Extending the PHEC benefit would provide seamless coverage to LTSS for this group. The majority of the population transitioned off PHEC and did not move to LTSS.
- OHA also considered how an extension of the PHEC benefit would **offset other existing costs to the Medicaid program**. For example, a PHEC extension may offset some nursing facility charges that would otherwise be paid under LTSS ($507 per day on average), or LTSS-paid in-home care charges of $38 per day. Current PHEC beneficiaries also experience a 21% rehospitalization rate, which is relatively high, within 30 days after the PHEC period. OHA anticipates that a PHEC benefit extension would reduce rehospitalizations, but did not model these potential savings for this analysis.
- OHA considered that extending the PHEC benefit could result in **increased admissions to nursing facilities** if coverage gaps are driving NFs to reject admissions of clients without LTSS coverage. However, they noted that extending the PHEC benefit does not address member suitability for nursing facility placement. Some members would be inappropriate for discharge to NFs regardless of the length of PHEC coverage.

OHA estimated the cost of extending the PHEC benefit under two scenarios.

- Scenario 1. **If the number of OHP enrollees utilizing PHEC benefits remains stable (n=157)**, the net cost to extend the benefit would be: $0.3 million for 30 days of coverage; $0.8 million for 60 days; or $0.9 million for 100 days. These estimates include the direct increase in facility costs to OHP, minus cost offsets to LTSS.
- Scenario 2. **If the number of OHP enrollees utilizing PHEC benefits increases by 50%,** the net cost to extend the benefit would be: $1.3 million for 30 days of coverage; $1.9 million for 60 days; or $2.2 million for 100 days. OHA felt this was the more reasonable basis for estimating costs, if the Task Force advanced a recommendation to change this benefit.

SNF Benefit (Dual-eligible Medicare and Medicaid enrollees)

OHA also analyzed the SNF benefit for dually-eligible Medicare/Medicaid enrollees. Medicare pays for up to 100 days of SNF care after a 3+ day inpatient hospital stay. Beginning at day 21, patients are responsible for a $200 per day copay. For OHP members, this copay is covered by OHA (not CCOs or members).

The population accessing this benefit is much larger than the population using PHEC coverage. From July 1, 2022 to June 30, 2023, there were 2,067 enrollees with medical (not LTSS) claims for SNF coverage. Most of these enrollees were dually-eligible for Medicare and Medicaid and enrolled in OHP fee-for-service coverage (n=1,841).

Costs to the Medicaid program for NF stays for this population totaled $7.2 million, averaging $110 per person per day (often $200 per person per day after day 20). These claims are exclusively OHP fee-for-service; there is no CCO liability for these claims.

For these enrollees admitted to NFs, discharges occur gradually from days 1-100, with an acceleration of discharges occurring after 20 days. This discharge trend over 100 days was used as the basis for modeling an extended PHEC benefit.

Conclusions

OHA summarized key takeaways from these analyses.

Potential benefits of extending PHEC coverage to 30, 60 or 100 days include:

- Earlier discharge from hospitals;
- Nursing facilities may increase acceptance of post-hospital patients;
- Case managers have additional time to coordinate LTSS coverage or other post-hospital care needs;
- The risk of rehospitalization may be reduced.

Potential costs include:

- A direct increase in medical costs to OHP;
- A potential increase in admissions to nursing facilities;
- Costs would be partially offset by savings from existing LTSS claims;
- There may be additional offsets resulting from reduced hospitalizations.

Finally, OHA noted that members may wish to focus on a 60- or 100-day extension of PHEC coverage. The 30-day option is less than a typical LTSS determination period (45 days) and may not address the PHEC-to-LTSS coverage gap.

Member Discussion

Chair Jones facilitated member discussion of the presentation.

Chair Jones asked why the Task Force would not want to consider the 100-day option. Are there downsides to this beyond the cost?

- OHA noted that the cost is the primary consideration. There may also be a desire to avoid people staying in skilled nursing care longer than necessary, given PHEC is intended as bridge coverage to other types of care. These issues could also be addressed on the operational side.

Chair Jones asked if choosing a 60- or 100-day option would materially alter the discharge destination of patients after a hospital stay.

- OHA noted this seems unlikely but suggested industry representatives may be able to speak to this.

Phil Bentley asked ODHS if they could speak to the differences in eligibility criteria for PHEC and LTSS, and for people who transition between them, is there unreimbursed care occurring at the transition?

- Jane-ellen noted that they have heard anecdotally that NFs are declining referrals of Medicaid patients because the CCO determines how many days of PHEC coverage to authorize. A CCO may authorize only a few days of PHEC coverage, which is why NFs want to see LTSS coverage in place prior to NF admission.

Eve Gray asked how this PHEC population data relates to data on avoidable hospital days. Do we know how many avoidable hospital days would be prevented if this benefit were extended?

- OHA noted this is a relatively small population. Improving coverage for this population would come at a very modest cost. It will not be a "sea change" that solves hospital discharge delays on its own, but it would be a reasonable incremental improvement.
- Ray Moreno noted that one person discharging twenty days earlier from a hospital is significant; it can mean treating four additional people with 5-day stays for heart attack, stroke, bowel obstruction, etc. This is a small portion of a big problem, but it is within the Task Force's scope to do at a very modest cost. This would be a good thing for the Task Force to recommend.
- Trilby de Jung concurred with Dr. Moreno that while this is a small population, it is an opportunity for tangible improvements. She noted that they would like to increase CCOs' engagement in helping coordinate these transitions for their members. This is a meaningful opportunity to do that, helping OHA leverage engagement with the CCOs.

Jeff Davis noted that PacificSource voluntarily offers a 20-day extension of the PHEC benefit across all of its CCO regions. The estimated 50% increase in NF admissions (OHA's scenario 2) tracks closely to their experience. Their NF rates increased during this time period as well, which is a confounding factor also driving increases in admissions, which they cannot separate out. He reported that their hospital readmission rate for SNF admissions is relatively low when looking at readmissions from day 1 of SNF admission (though he has not reviewed data for 30-days post discharge from SNFs). One risk is that SNFs may be less likely to reach out to ODHS to start the LTSS process as early as they need to if there is a longer time frame before the PHEC benefit is exhausted. They may need to be encouraged to do so if the benefit were extended statewide.

Jeff Davis also noted that for Medicare patients with a $200 copay obligation after day 20, many are unwilling to cover this and will discharge at that point.

- OHA affirmed this point and clarified that for dually-enrolled (Medicare and Medicaid) members, the state is paying that $200 day copay, so this should not be driving discharges of those enrollees.

Ray Moreno commented that he is very supportive of extending the PHEC benefit. These data mirror their experience that every facility is trying to navigate a difficult situation of admitting patients with uncertainty about their coverage, managing risk as best they can. This extension would remove some of that

uncertainty by extending past the window for an LTSS determination. It also makes sense clinically, for example, for people who need six weeks of intravenous antibiotics.

Overview of Flexibilities to Streamline and/or Promote Medicaid LTSS

ODHS:

Jane-ellen Weidanz

(slides)

ATI Advisory:

Johanna Barazza-Canon

(slides 31-41)

The Task Force has previously discussed possible changes to streamline the LTSS eligibility determination process, which may help address delays in appropriate discharge from the hospital to LTSS-paid post-acute care. Today's meeting offered additional information about those options.

ATI Advisory reviewed how the state could make changes to certain aspects of the LTSS eligibility process. Their overview draws from a review of other states including Washington, California, and New York, who are developing new policies in this area and may offer insights for Oregon.

These changes include:

- **Presumptive eligibility**, such as 1) expanding OHP presumptive eligibility authority to coverage for LTSS; or 2) expanding PE authority from exclusively MAGI groups to include other groups such as the Medicare aged, blind and disabled group.
- **Asset test flexibilities**, such as 1) increasing the maximum asset limit that may be considered for eligibility for LTSS; 2) eliminating the asset test from consideration entirely, or 3) shortening the lookback period or using self-attestation in lieu of verified documentation.

Many of these changes require Section 1115 waiver authority.

Presumptive Eligibility

PE is a way to assess if a person appears to be eligible for certain services in Medicaid. Many states have implemented PE for coverage of hospital services. A hospital, if it is a qualified entity, can determine that someone appears to be presumptively eligible for Medicaid, allowing for payment of hospital services pending full verification. Generally, if a person is later determined not to be eligible, the provider is not responsible to refund claims paid for services during the PE period.

ATI noted that when determining PE, it is generally more straightforward to determine eligibility for MAGI groups based on things like income, citizenship, etc. It can be more complex for a qualified entity to determine PE for people in non-MAGI categories because of the need to complete a functional assessment and care plan.

States including California and Washington have sought federal waiver authority to expand PE to LTSS or use PE to cover new groups.

- **Washington** state established a PE process for two of its waiver-funded home and community-based services programs.
- **California** expanded PE to a new eligibility group of individuals age 65 or older who are not eligible for Medicare and have incomes up to 138% of the federal poverty level.

Some considerations for states include:

- Section 1115 applications are quite time consuming. CMS has a queue of pending waiver requests and likely will not approve additional requests in the next year. Waivers also must be budget neutral to the federal government.

- New operational processes must be developed to demonstrate to CMS that a program can be implemented. These processes can include training new qualified entities to conduct PE authorizations that meet CMS requirements. The process can be much more complex than hospital PE due to the functional assessment requirement.
- If presumptive eligibility creates an entitlement to short-term LTSS, and someone is later determined ineligible, they could appeal the determination and the case would need to go through due process with an administrative judge before their case could be closed.

Jane-ellen Weidanz offered ODHS' perspective on these potential changes and things for the Task Force to consider.

- PE authority for LTSS may be worth pursuing; it would need to be done thoughtfully and members should consider that due to waiver approval timelines, this is not a near-term option to expedite LTSS determinations.
- For other states that have done this, the benefit has been defined narrowly; a person self-attests to their eligibility, there is a high level of screening, and the state (or its contractor) has a limited time to verify eligibility. Oregon would need to consider a similar approach.
- ODHS has been leading a workgroup to develop a screening tool that helps communicate which individuals are likely to be eligible for LTSS. They hope this tool will help community partners, including hospital discharge planners, understand the eligibility determination process up front.

Asset Testing Flexibilities

The federal government requires asset testing to prevent people from accessing Medicaid-paid long-term care if they have personal assets that could be used to pay privately for care. Asset testing procedures vary across states, but often limit assets to no more than $2,000 per individual or $3,000 per couple. There is typically a 5-year lookback period to prevent people from giving away assets to qualify for Medicaid LTSS. The rigor of the process can delay care even when a person is eligible.

Some states are taking a longer-term view that while a rigorous asset testing process may reduce costs, it can create substantial barriers to care for eligible people.

- Among states, only **California** has fully eliminated the asset test for non-MAGI populations who otherwise meet the functional needs criteria for LTSS.
- **New York and Vermont** have used 1115 waiver authority to expand asset limits. New York limits assets to $30,183 per individual or $40,821 per couple. Vermont limits assets to $10,000 per individual. The rationale is that assets below these levels are not sufficient to purchase long-term care.
- **New Jersey** has not changed its asset limit but has moved to self-attestation of assets to administratively streamline the process.
- **New York** has shortened its lookback period from 60 months to 30 and the state is considering an even shorter period.

Some considerations for states include:

- As with PE, these changes require federal negotiations, which are time consuming for states, and are subject to federal approval.

- This area benefits from analyzing data to understand more specifically where people may become delayed in the asset verification process, or what circumstances are most often disqualifying.
- Analysis is recommended to model how the population of eligible people would change under different asset testing scenarios, given that waivers must be budget neutral. There are ways to tailor asset test changes to target specific challenges.

Jane-ellen Weidanz offered ODHS' perspective that due to waiver approval timelines, this is not a near-term solution that could streamline LTSS determinations. While it may be beneficial longer term, ODHS needs the Task Force to clarify whether this is a high priority for the agency to pursue to address discharge challenges in the state.

Member Discussion

Vice Chair Burns facilitated member discussion of these concepts.

Jane-ellen commented that the lookback period and process are quite complicated for individuals applying for Medicaid. The lookback is not focused on specific transactions. It requires individuals to justify changes in net assets over a five-year period.

- ATI agreed and noted that while it is important to ensure public funds are spent correctly, some of this administrative process creates meaningful delays in care.

Phil Bentley noted these changes are very complex and potentially costly. He was surprised to learn the state could lift asset tests entirely and wondered if this differentiates between income and assets? [ATI confirmed this is correct]. He noted that under current Medicaid redeterminations the state is completing, an estimated 35,000 people could lose LTSS coverage. Does this address that challenge? Does this change require legislative approval? Is this a priority for the Task Force to make a recommendation that the legislature or ODHS pursue this further?

- Eve Gray commented that the Task Force does not have a sense for what this would cost or whether it could be budget neutral to gain waiver approval. She noted the state has several new Medicaid benefits rolling out over the next year. She is concerned about recommending OHA or ODHS pursue additional waiver changes before these new efforts have been implemented or their costs established. She sees value in these changes but felt this may not be the right time to pursue them.
- Felisa Hagins supported ATI's suggestion to do additional modeling of these changes. She would like the Task Force to recommend that the agency model these changes, including studying both fiscal impacts and equity impacts. She noted that it does not make sense to deny services that could keep individuals at home because they own assets such as a car, when this results in individuals being unnecessarily institutionalized at the end of their life. Vice Chair Burns agreed with this point.
- Alice Longley Miller noted that asset testing changes have been a priority for the disability community. Asset limitations can also impact how people with disabilities are able to participate in the workforce. She agreed with the need for financial modeling of these potential changes, including studying workforce implications.

- Jane-ellen noted the asset limits have not been raised since 1987. These limits were intentionally set to discourage people from seeking assistance, at a time when states also engaged in practices such as searching people's homes without notice to verify that they were not lying about food assistance needs. She noted that one approach to simplify a federal waiver request would be for ODHS to pursue this as a new 1115 waiver separate from Oregon's other existing waivers.
- ATI affirmed that states can pursue additional 1115 waivers. One consideration is whether a state wants to use savings from one program to pay for other new investments. Budget neutrality is calculated separately for each waiver.
- Jeff Davis affirmed that he has often seen a medically fragile person in the hospital who is unable to qualify for LTSS because they do not want to give up possessions or a home. This can result in people being discharged to home without adequate supports and then ending up back in the hospital.

Phil Bentley commented that given Oregon's work in other areas of Medicaid eligibility, he is surprised that the approach to asset testing has not been changed. Is this because the cost would need to be offset? What has prevented this from being changed since the 1980s?

- Felisa Hagins responded that discussions about changing asset limits often raise concerns about Medicaid fraud or people trying to "scam" the system to access benefits. The state needs to more comprehensively examine asset testing and other racist welfare reform policies from the 1980s across programs. Some of that is beyond the scope of the Task Force's recommendations, but the state overall should pursue this. Vice Chair Burns agreed.
- Alice Longley Miller noted that the federal government's position on asset testing has also changed in recent years. Where they were not previously willing to cover federal match, they are showing willingness to work with states on this now.
- Jane-ellen Weidanz agreed, noting some states have historically had higher asset limits but overall Oregon is in line with the national trend across states. Pacific Northwest housing costs have risen much faster than other parts of the country, so the same asset limit in Oregon is much more restrictive than in another state with more affordable cost of living.
- ODHS has done some initial cost estimates of asset test changes and can share those at a future meeting. Jane-ellen noted that at the federal level, Medicaid policy is skewed toward coverage of medical and institutional services rather than home or community-based care. Oregon's focus in recent years on expanding OHP medical coverage has been possible because the federal government was receptive to those changes in a way that has not been true for changes in HCBS.

Phil asked if the group wants to advance a recommendation around asset test changes given Task Force discussions? He does not think these issues can be resolved in the near term.

- ATI noted that it may be worth ODHS and OHA exploring whether there are administrative or operational changes that could be made without a waiver that could still simplify the asset test process. The agencies could assess

	these possibilities in the short term while studying waiver opportunities longer term. • Eve Gray commented that there are clear societal benefits to these changes under a waiver. However she wants to understand if the agencies are already planning to pursue these changes before considering making a recommendation, given the number of other waiver changes in progress. • Felisa Hagins commented that the Task Force could recommend agencies begin studying these concepts now in preparation for the 2028 waiver cycle, which is a multi-year planning effort. She also asked the Task Force to consider a recommendation that the agencies immediately pursue a waiver of the asset test for people who meet HUD's definition of homelessness. • Jane-ellen commented that ODHS will explore whether APD could use other programs' definitions, such as HUD, within the LTSS determination process. • ATI commented that many states use information in that way across programs for MAGI eligibility groups. For non-MAGI populations, the need for a functional assessment becomes the challenge, even when financial assessments are simplified. • Ray Moreno affirmed others' comments that the current asset limits are unreasonably low and inconsistent with the state's other goals. This should be a priority to fix. Jane-ellen noted that one of the biggest factors contributing to LTSS determination delays right now is the shortage of case managers. This is an area that doesn't require a waiver and is within the state's ability to influence now. • Ray Moreno affirmed this point and commented that if the state can bolster case manager staffing to expedite the existing eligibility process, rather than pursuing a PE waiver, this may be a more effective way to address the short term delays. • Phil Bentley agreed with Dr. Moreno that he would like to see the group advance a recommendation related to the LTSS eligibility process. The Task Force has considered several options to do so and needs to narrow in on what is most desirable from those options.
Public Comment	• Dr. Maria Niemuch, Northwest Human Services (link) • Marty Carty, Oregon Primary Care Association (link)
Meeting Materials	• May 2024 Meeting #8 Summary (link) • Staff slides (link) • ATI Advisory slides and data appendix (link) • Burns and Associates slides (link) • Oregon Health Authority slides (link) • Oregon Dept. of Human Services slides (link)