OHCA
OREGON HEALTH
CARE ASSOCIATION

August 27, 2024

Jimmy Jones, Chair
Dr. Elizabeth Burns, Vice Chair
Joint Task Force on Hospital Discharge Challenges
Oregon State Legislature
900 Court St. NE
Salem, OR 97301

Re: Long Term Care Priority Policy Recommendations

Dear Chair Jones, Vice Chair Burns, and Members of the Joint Task Force,

Oregon Health Care Association (OHCA) represents more than 90 percent of long term care providers across the state. Our members include post-acute care, long term care, assisted living, residential care, and memory care communities, as well as in-home care agencies. We are deeply committed to serving all older adults and people with disabilities in need of long term services and supports, as well as those caregivers and clinical staff who care for them.

We are grateful for the work of the Joint Task Force on Hospital Discharge Challenges and are aligned with its guiding principles: That recommendations be consensus, reduce discharge delays, be patient-centered and considerate of the needs of housing insecure individuals, and are actionable in a manner that does not shift backlogs to other parts of the care continuum.

We recognize the complexity of the Task Force's statutory charge as well. In these final months of deliberation, we offer our view of which proposed policies in the "*Policy Concepts for Consideration*" memo drafted by LPRO (June 28, 2024) have our support. If fully implemented and appropriately funded, these policies would provide meaningful outcomes for long term care providers and help the post-acute sector better partner with hospitals and other social service providers to serve Oregonians.

Finally, we must acknowledge two realities. First, the Task Force has taken on a wide array of policies, some of which may not relate directly to post-acute care. Simply because we have not called out those policies in this letter does not mean we oppose them and understand they may be included in the Task Force's final recommendations. Second, many of these policies require further development to arrive at the level of detail needed to make them actionable. We believe this is where the Task Force should focus conversation for its September, October, and November meetings.

1. **Remove systemic barriers to access Medicaid long term services and supports (LTSS):** The top priority of the Task Force should be to remove or resolve the barriers that hamper access to care for Medicaid beneficiaries. This includes improvements to the Medicaid eligibility process, which is a root cause of hospital discharge delays.

   For this recommendation to be operationalized, clarity of scope is needed from the Oregon Department of Human Services (ODHS). The Task Force should ask for a detailed budget, implementation plan, and determination of whether components require approval from the Centers for Medicare and Medicaid Services (CMS).

   A successful outcome would be for most Medicaid applications to be approved or denied within a **10-day period** for individuals awaiting discharge from a hospital. For applications that cannot be expeditiously resolved, we recommend the state adopt a triage framework that allows for timely determination given the current resources allocated for this work. For individuals who already reside in a long term care facility, a **30-day** determination period would be acceptable. The Task Force should also direct ODHS to explore utilization of technology and systems improvements that enhance automation and reduce manual processing of Medicaid applications and casework.

   Finally, we would offer a note of caution on the concept of implementing presumptive eligibility for long term services and supports (policy **1.3**). Presumptive eligibility must be structured in a manner that guarantees long term care providers will not be saddled with unpaid debts if individuals presumed to be eligible are admitted into facilities and are then determined to be ineligible for Medicaid-covered long term care services and supports. Unlike hospital settings, many long term care communities serve as an individual's *home*. This contingency could potentially be addressed by establishing a state fund to cover those costs, but it is not clear today how that would be structured or if there are General Fund resources available for this purpose. The Task Force should direct ODHS to work directly with long term care providers to determine and clearly understand these details *prior* to moving forward with presumptive eligibility. This will ensure the Task Force avoids moving individuals to post-acute settings without a clear payor source, which exacerbates underlying financial and capacity issues.

   Associated LRPO policy proposals supported by post-acute care:
   - ***1.1*** *The Legislature should 1) allocate funding for ODHS caseworker positions using a methodology that accounts for individuals who do not have a paid provider and accounts for varying complexity of cases, 2) direct agencies to establish dedicated teams of case workers (APD, AAA, and OHA-BH) who specialize in eligibility assessments for complex cases, and 3) increase AAA/APD caseworker staffing to improve wait times for LTSS determinations.*
   - ***1.4*** *ODHS and OHA should provide guidance to local case workers on how to intervene when a delay occurs in LTSS financial assessment.*

- ***1.5*** *ODHS and OHA should 1) develop an integrated process to streamline functional assessments across programs, 2) publish caseworker expectations for: assessment scheduling, communication with hospitals, and expected response times, and 3) provide training to case workers and hospital discharge staff to align expectations.*

- **Develop Tools for Understanding Post-Acute Sector Capacity:** There is value to pursuing better escalation protocol, care coordination, and education between acute and post-acute care settings. However, we caution the Task Force against advancing policy recommendation **1.8** *unless* it is paired with resources to make it useful and reflect true capacity accounting for staffing, acuity, and regulatory compliance. Simply because a nursing facility has an "open" bed does not mean it can necessarily admit any new resident because of the complexities of the long term care regulatory environment. While there may be value in creating a central tool to understand where post-acute capacity exists in the state, this concept needs further refinement before we could endorse a particular approach. Post-acute providers would likely need their own tool and/or database that could account for the differences in these settings versus hospital settings. At this time, we do not believe the APPRISE system would accommodate the needs of post-acute care providers.

  Associated LRPO policy proposals supported by post-acute care:
  - ***1.8*** *OHA and ODHS should 1) create a centralized database of post-acute facilities with real-time numbers and types of placement openings, and 2) train hospital discharge planners on use of the system. OHA should explore whether the APPRISE Health System could add this functionality to the Oregon Capacity System, including tracking of facilities with specialized needs contracts (support only with changes above).*
  - ***1.11*** *OHA and ODHS should provide guidance and training to hospital discharge planners, case managers, and post-acute facilities to align expectations on which care settings are appropriate for patients with certain complex needs.*

- **Extend OHP Post-Hospital Benefit (PHEC):** Extending the PHEC would be of value to consumers and the acute and post-acute care systems. The Task Force needs to better understand the fiscal impact of such a change but should move forward with this extension as a final recommendation. We support extending the benefit to align with the maximum length of a Medicare-covered to stay to 100 days. There is also an opportunity to also model this benefit on managed Medicare plans that allow for coverage in a community-based care setting. For example, if a resident is ready to be discharged after 50 days in a nursing facility, then the extended PHEC benefit under OHP should also cover up to 50 more days in an assisted living community or home environment with in-home care services.

  Associated LRPO policy proposals supported by post-acute care:

- ***3.6*** *The legislature should extend the OHP post-hospital extended care (PHEC) benefit to 60 or 100 days (Medicaid-only enrollees).*

- **Enhance Regulatory Alignment and Reduce Disincentives:** Long term care facilities are highly regulated by state and federal rules. Some of these rules constrain admission and care for residents with complex care needs. Today's regulatory system does not incentivize providers to serve the kind of high-acuity residents that hospitals are challenged to discharge. Preventing undue burden and cultivating a more collaborative regulatory environment will allow providers to deliver effective, high quality care while moving patients through the care continuum in a safe and efficient manner.

  We support the Task Force recommending an assessment of regulations with the goal of ascertaining whether policies could better align with the evolving needs of individuals seeking care in our long-term care system. Completing this assessment and acting upon its results is even more imperative as the state explores new and innovative models of care developed with this population in mind.

  Associated LRPO policy proposals supported by post-acute care:
  - ***4.1*** *ODHS Safety, Oversight, & Quality (SOQ) should conduct a study of administrative rules that may create barriers to facilities accepting residents with complex care needs. SOQ should 1) compare regulations for acute care hospitals, and long-term care settings that accept post-acute patients from hospitals, to identify areas where regulations could better align across acute and post-acute settings, and 2) pilot changes to these facility regulations to test whether they address perceived as barriers to complex care admission/delivery.*
  - ***4.2*** *The legislature should 1) allow greater flexibility for long-term care facilities to initiate involuntary move-out orders of residents to reduce perceived risk of admitting high acuity residents, 2) establish support to facilities to recoup costs of involuntary move-out orders, and 3) establish support to residents who are issued involuntary move-out orders to navigate relocation or address factors contributing to move-out order.*
  - ***4.3*** *SOQ should 1) reduce civil monetary penalties on post-acute providers with violations, and 2) provide support to facilities with residents presenting challenging behaviors due to mental health or substance use conditions. Support could include technical assistance or agency guidance in lieu of corrective actions.*

- **Health Care Workforce Development:** Availability of a trained long term care workforce is one of the most crucial factors that impacts capacity in all post-acute settings. Our workforce has lost more than 400,000 jobs nationally since the start of the pandemic and most communities are facing a workforce crisis.

  Nursing facilities are subject to state-mandated nursing assistant staffing ratios and will soon be subject to new federal minimum nursing staffing requirements, including having an on-site RN 24 hours a day, seven days a week. If facilities cannot meet these ratios,

they must cap census, which limits capacity. Community-based care facilities, while not subject to staffing ratios, are required to utilize a rigorous acuity-based staffing model. Consequently, Oregon staffing levels in long-term care settings are some of the highest in the nation while our public nursing schools produce the fewest number of new RNs per capita of any state.

Given the inextricable link between workforce availability and system capacity, we believe the Task Force should prioritize policy and budget proposals that would grow the workforce pipeline in Oregon, increase the capacity of our nursing schools, and incentivize nursing graduates to choose a career in post-acute care for a specified period through loan repayment and other programs.

Associated LRPO policy proposals supported by post-acute care:

- ***5.5*** *The legislature should 1) direct public higher education institutions to benchmark nurse faculty salaries to local industry rates, and 2) match faculty compensation to industry rates.*
- ***5.10*** *The legislature should forgive nursing student loans and offer other incentives for students who 1) choose careers in post-acute care, or 2) become nurse faculty.*

Lastly, the LPRO's Policy Concept document includes a handful of policy proposals related to home and community-based Medicaid reimbursement rates and wages for direct care workers. While some of these concepts have our support, we believe that proposals related to minimum wages and wage pass-through requirements (policies **3.4** and **3.5**) are outside the scope of the Task Force's charge.

We appreciate the opportunity to provide feedback on behalf of long term care providers across Oregon and look forward to partnering with the Task Force and Legislature on implementation of key policies to improve care for all Oregonians.

Sincerely,

Phil Bentley
President and CEO
Oregon Health Care Association

Cc: Daniel Dietz, Legislative Analyst, Legislative Policy and Research Office
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