ATI Advisory

RESEARCH AND POLICY BRIEF:

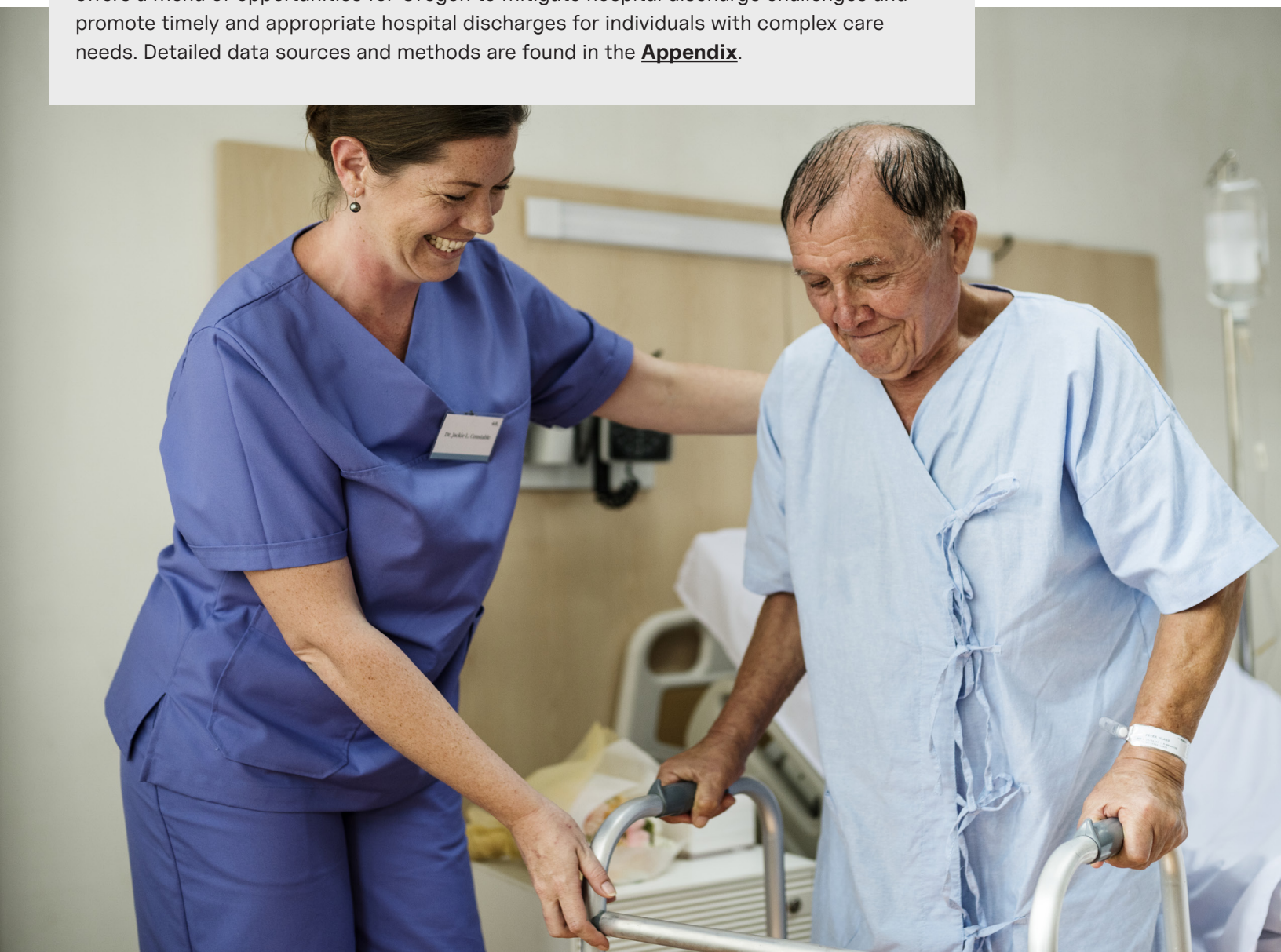
Opportunities for Oregon to Promote Timely and Appropriate Hospital Discharge for Individuals with Complex Care Needs

August 2024

Contents

About this Work

In August 2023, Oregon House Bill 3396 (HB3396) established the Oregon State Legislature's Joint Task Force on Hospital Discharge Challenges (hereafter referred to as "the Task Force"). To fulfill HB3396's directive, the Oregon Legislative Policy and Research Office (LPRO) contracted with ATI Advisory (ATI) to provide the Task Force with a better understanding of the barriers to timely and appropriate hospital discharge – particularly for individuals with complex care needs – while identifying feasible, practical, and sustainable solutions to address these barriers. Rooted in research, data analytics, and insights from a diverse coalition of Oregon stakeholders across state agencies, post-acute care providers, health plans, labor groups, housing service providers, and more, this report offers a menu of opportunities for Oregon to mitigate hospital discharge challenges and promote timely and appropriate hospital discharges for individuals with complex care needs. Detailed data sources and methods are found in the **Appendix**.



Topline Summary

- Like many hospitals across the U.S., Oregon's hospitals are experiencing significant challenges discharging individuals with complex care needs related to behavioral health, substance use, and long-term services and supports (LTSS) to appropriate post-acute care settings. In many instances, these individuals may not have a residence or are not able to return to their residence without support with their activities of daily living or other wrap around services (e.g., home accessibility modifications, meals). Medicaid financial and functional eligibility assessments to determine if an individual qualifies for these services are time-intensive processes that can further delay the hospital discharge process.
- Meanwhile, many post-acute care providers (e.g., skilled nursing facilities, home health agencies) lack the specialized services and supports necessary to serve individuals with complex care needs, particularly behavioral health needs. These issues are compounded by challenges in recruiting and retaining staff, particularly direct care workers.
- Delayed hospital discharges have negative impacts on hospitals, payers, communities, caregivers, and – most importantly – the patients who are left without timely connections to critical post-hospital services and supports and, as a result, must remain in the hospital after they are ready for discharge.
- States – particularly agencies and departments connected to Medicaid or offering services for older adults and people with disabilities / behavioral health needs – have significant administrative, regulatory, and payment levers of influence to enable more timely and appropriate hospital discharges for individuals with complex care needs.
- Rooted in research, data analytics, and insights from a diverse coalition of Oregon stakeholders, this report:
  1. Describes the specific barriers and challenges confronting Oregonians and their families / caregivers, hospitals, providers, payers, and communities; and
  2. Offers a menu of opportunities for Oregon to alleviate hospital discharge challenges and promote timely and appropriate hospital discharges for individuals with complex care needs.
- Opportunities include strategies for Oregon policymakers and their industry partners in the following areas:

Opportunity Area 1: Supporting Providers in Developing Capacity and Skills to Serve Individuals with Complex Care Needs

Oregon can invest in workforce programs and partnerships that create opportunities for individuals to enter the direct care workforce and develop skills to meet complex care needs. Additionally, the state can explore payment policies that reimburse based on patient acuity and incentivize providers to invest in critical clinical and caregiving capabilities, and resources that are needed to support individuals with complex care needs.

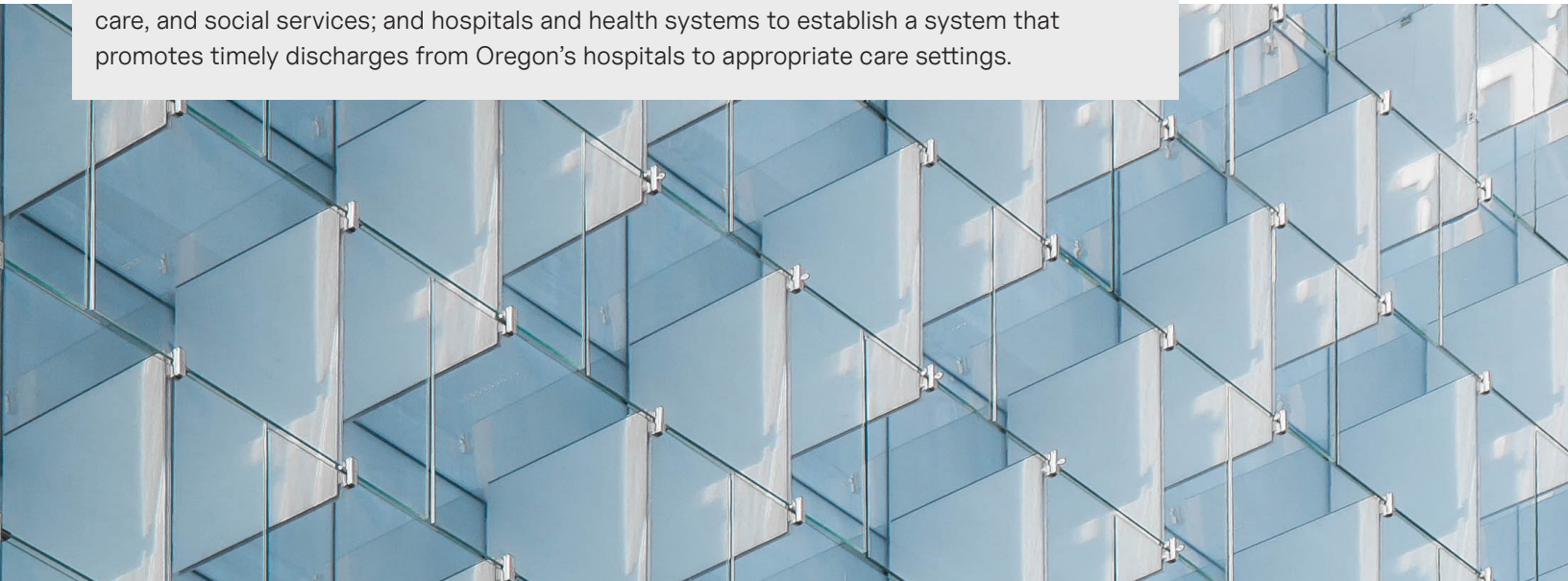
Opportunity Area 2: Driving Innovation through New or Expanded Settings and Coverage

Oregon can enable new or expanded settings and coverage options to address the lack of appropriate care settings for unhoused individuals and individuals with co-occurring physical and behavioral health needs. This could include strategies such as covering new services like medical respite, and enabling specialized, facility-based care delivery models equipped to serve individuals with complex care needs (e.g., special contract skilled nursing facilities).

Opportunity Area 3: Streamlining the Hospital Discharge and Medicaid Eligibility Processes

Oregon can improve and expedite processes related to patient discharge, including screening and eligibility determination processes for Medicaid LTSS. This includes improving connections between hospitals, state and local agencies, Coordinated Care Organizations (CCO), and providers when preparing for discharge. This also includes more expansive action such as pursuing federal approval through Section 1115 demonstration authority to streamline Medicaid eligibility assessments to place individuals in care settings more quickly (e.g., expanding Medicaid presumptive eligibility to include LTSS and eliminating or increasing the Medicaid asset test limit).

This report can serve as an actionable resource for Oregon; health plan partners across Medicare and Medicaid; providers across post-acute care, LTSS, behavioral health, primary care, and social services; and hospitals and health systems to establish a system that promotes timely discharges from Oregon's hospitals to appropriate care settings.



Key Terms and Coverage Snapshot

The following terminology and snapshot of Oregon's coverage and delivery system landscape is used throughout the report to support a common understanding of key terms and state levers of influence.

- Individuals with **complex care needs** as used throughout this report refer to individuals with significant and often co-occurring and / or intersecting needs and services spanning physical health, behavioral health, functional and cognitive ability, and the social drivers of health (e.g., housing, transportation, social connection, nutrition). ATI's focus on these complex care needs was informed by stakeholder experiences and perspectives shared in Task Force meetings, ATI's key informant interviews and provider survey, and hospital discharge challenges as experienced in other states. Throughout this work, ATI sought to complement these qualitative experiences and insights with a quantitative understanding of hospital discharge experiences for individuals with complex care needs.
- **Post-acute care** as used throughout this report is consistent with definitions within Oregon House Bill 3396 and relevant Oregon Revised Statutes.[1] Accordingly, post-acute care settings within this report are inclusive of (1) Medicaid-funded, long-term care provided in institutional settings and home and community-based settings (often referred to as long-term services and supports [LTSS]) and (2) Medicare-funded shorter-term settings (e.g., skilled nursing facilities, home health).
    - **LTSS** are needed by individuals experiencing difficulty with activities of daily living, self-care, and disease management. LTSS includes extended nursing home stays and personal care services. In Oregon, LTSS are financed and delivered through a shared accountability system between the Oregon Department of Human Services (ODHS), local Aging and People with Disabilities (APD) / Area Agencies on Aging (AAAs) and Coordinated Care Organizations (CCOs) (please see term below). Under the shared accountability model, CCOs are responsible for referring their members who need or use LTSS (institutional or home and community-based services [HCBS]) to regional or county AAAs / APD. Local AAAs / APD manage and monitor most LTSS, including eligibility determinations and authorizations, while CCOs are required to develop a Memorandum of Understanding (MOU) with AAAs / APD to guide coordination and alignment between LTSS local offices and CCOs.
- The **Oregon Health Plan (OHP)** is Oregon's Medicaid program. As of June 2024, nearly 1.4 million Oregonians are enrolled in the OHP, representing 33% of all Oregonians:[i]

91.7%
of OHP (Medicaid) members are enrolled in CCOs that can manage their physical health, behavioral health, and/or dental benefits.

1 Relevant Oregon Revised Statutes (ORS) include ORS 443.305 (in-home care services), ORS 443.014 (home health services), ORS 442.015 (skilled nursing facilities), ORS 443.400 (residential care facilities), and ORS 443.705 (adult foster homes).

- 91.7% of OHP members are enrolled in Coordinated Care Organizations (CCO)[2] for coverage of physical health, behavioral health, and / or dental benefits. The Oregon Health Authority (OHA) (Medicaid agency) currently contracts with sixteen, region-based CCOs who receive a global, per member per month payment to manage and administer these services. Importantly, as noted in the 'LTSS' definition above, LTSS are "carved out" from CCOs' global budgets and instead authorized and paid for by ODHS; CCOs must coordinate with local AAA / APD regional staff for the provision of LTSS but are not financially responsible for these services;[ii]
- 8.2% of OHP members receive physical health, behavioral health, and any dental benefits through fee-for-service (FFS) coverage (also referred to "open card" coverage). Oregon's Program All-Inclusive Care for the Elderly (PACE) program enrolls the remaining 0.1% of OHP members.[3]
- 8.7% (of all OHP members, inclusive of "open card", CCO, and PACE participants) received both OHP and Medicare (referred to as "fully dual eligible"; please see term below). These individuals may be served by one of seven CCOs that also operate or are affiliated with a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP).

→ **Dual eligible individuals**[iii] refer to people who are eligible for Medicare Part A and / or Part B and some form of Medicaid benefit. This includes full and partial benefit dual eligible individuals. As of June 2024, Oregon had approximately 183,000 dual eligible individuals, with approximately 130,000 (~70%) qualifying for full Medicaid (OHP) benefits (known as "fully dual eligible"), and approximately 55,000 (~30%) qualifying for partial Medicaid benefits[4] (known as "partial dual eligible").[iv] Important to the conversation on hospital discharge challenges, nationally, a quarter of dual eligible individuals (fully eligible for Medicare and Medicaid) receive help with their activities of daily living.[v]

→ **Dual Eligible Special Needs Plans (D-SNPs)** are Medicare Advantage plans that are designed exclusively for dual eligible individuals, have a contract with the Medicaid agency in the state in which they operate, develop a Model of Care to serve their dual eligible members, and coordinate Medicaid benefits for members. States have various opportunities to influence how D-SNPs operate. As of January 2024, 22.2% of dual eligible individuals in Oregon are enrolled in D-SNPs, compared to 41.5% of dual eligible individuals enrolled in D-SNPs nationally.[vi]

22%
of dual eligible individuals in Oregon are enrolled in D-SNPs.

→ **State Medicaid Agency Contract (SMAC)** refers to the contract between a D-SNP and the state in which it operates. The SMAC details D-SNP responsibilities, and it must include the 10 minimum regulatory requirements.[vii] This is a critical lever states can use to design D-SNP programs. In Oregon, the OHA administers and oversees the state's D-SNP program through the SMAC.

2 While most OHP members enrolled in a CCO have all types of their health care (physical, dental, and behavioral) covered by their CCO, some members have CCO coverage for behavioral and / or dental care only.

3 CCO enrollment is mandatory for most OHP members; those exempt (Tribal members and foster care youth) receive OHP fee-for-service, or "open card" coverage. OHA and ODHS are payers for "open card' OHP members.

4 Partial dual eligible individuals do not receive OHP benefits, but Medicaid helps pay their Medicare cost sharing (such as premiums and deductibles).

- **Social-needs benefits**, also referred to as **"health-related"** benefits are services that address non-medical care needs of individuals, spanning transportation, housing, food, social supports, and more. In Oregon, CCOs / D-SNPs have flexibility to offer social-need benefits. CCOs do so through Health Related Services (HRS) and Health Related Social Needs (HRSN) services. CCOs that also operate D-SNPs in the state may also provide social-need benefits through Medicare Advantage supplemental benefit authorities.
- **Health Related Services** are non-OHP-covered services that CCOs can choose to pay from their global budgets. They are offered as supplements to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being. HRS can cover a wide variety of services including limited housing assistance and recuperative care. These payments can be at the community level (**"community benefit initiatives"**) or individual level (**"flexible services"**).
- **Health Related Social Needs** benefits are required, covered services for certain populations through Oregon's Section 1115 demonstration. HRS will continue through the duration of Oregon's current Section 1115 demonstration (approved through September 2027), but are not required, for populations who are not categorically eligible for HRSN. HRSN implementation is ongoing. All Medicaid-eligible groups[5] are eligible for HRSN benefits if they belong to an allowable priority population[6] and meet medical appropriateness based on clinical and social risk factors.[viii]
- **Medicare Advantage Supplemental Benefits** are services that are not covered by Traditional Medicare but that Medicare Advantage plans, like D-SNPs, may offer. They can be offered to all or a subset of plan members depending on whether a plan offers them under the Expanded Primarily Health-Related Benefit, Special Supplemental Benefits for the Chronically Ill, or Value-Based Insurance Design model authorities.[ix] Supplemental benefits include services such as dental, vision, hearing, fitness membership, transportation, food and produce, and home modifications.[7]

5 Excludes the Expanded Adult Program population (adults with incomes 133-200% Federal Poverty Line) regardless of meeting allowable target population criteria.

6 Allowable priority populations with most relevance to the Task Force include: (1) adults discharged from an Institution for Mental Disease, residential mental health and substance use disorder facility, or inpatient psychiatric unit; (2) adults being released from incarceration; (3) those transitioning from Medicaid-only to dual eligibility status; (4) those who are homeless or at risk of becoming homeless as defined by U.S. Department of Housing and Urban Development in 24 CFR 91.5; and, (5) those with a high-risk clinical need who received in a region experiencing extreme weather events.

7 Additional information, including background, data insights, and policy opportunities regarding Medicare Advantage supplemental benefits can be found on ATI Advisory's Advancing Nonmedical Supplemental Benefits in Medicare Advantage resource page (link).

A Note on Systemic Issues Impacting State Ability to Address the Hospital Discharge Crisis

This report outlines several policy solutions to achieve timely and appropriate hospital discharge for individuals with complex care needs, specifically in Oregon. However, given the complexity of the issues – and interactions across healthcare, housing, and social services – systemic challenges beyond those expressly explored in ATI's work and by the Task Force will remain, even if policy opportunities enumerated in this report were enacted. Federal action at the legislative and executive levels will be needed to significantly address these challenges to supplement the policy opportunities outlined in this report:

- **There are workforce shortages in healthcare, compounded by demographic pressures, which reduce the number of direct care workers available in the settings where patients need to be discharged.** The United States has experienced a shortage of direct care workers for decades, but this shortage has become especially acute in recent years.[x] The supply of direct care workers will fall short of demand in the years to come, with 8.9 million projected job openings from 2022-2032.[xi] Meanwhile the population of older adults over age 65 is expected to rapidly climb by 31 percent between 2022-2035.[xii]

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- **Substance use and behavioral health treatment shortages further complicate the needs of individuals both in and out of the hospital.** Substance use has grown to the point that two-thirds of adults across the United States report they have been impacted personally or within their family in some way by addiction.[xiii] Yet there is a shortage of mental health treatment, with a third of Americans living in an area with a shortage of mental health workers.[xiv]

- **Individuals increasingly lack family or other caregivers to support care needs in the community, making it difficult for them to discharge home with necessary supports and leading to social isolation.**[xv] In 2023, 34 percent of adults aged 50–80 across the United States reported feeling isolated from others in the past year. This is a reduction relative to rates during the COVID-19 pandemic in 2020 (56%), however it is significantly higher than the 27 percent who reported feeling isolated in 2018 prior to the pandemic.[xvi] Nationally, almost a third of Medicare beneficiaries who reported difficulty with activities of daily living live alone, which may mean that they do not have the needed supports in their home when they are discharged from the hospital, ultimately potentially delaying discharge.[xvii] Spouses can often provide a built-in support system, but less than half of Medicare beneficiaries reporting difficulty with activities of daily living report that they are currently married.[xviii]

- **Nationwide, there is not enough supply of affordable and accessible housing options, which has led to a national homelessness crisis.**[xix] This lack of housing is a key barrier to discharging individuals facing housing insecurity from the hospital in a timely manner. The overall dearth of affordable housing options is especially challenging for older adults with disabilities who need accessible housing.

Issue Overview

THE NATIONAL HOSPITAL DISCHARGE CRISIS

Nationwide, hospitals face increasing challenges discharging patients in a timely manner. Individuals, on average, stayed 19 percent longer in the hospital in 2022 than in 2019. The discharge crisis is affecting all states. For example, in California, an estimated 300,000 hospital patients (9% of all patients discharged from a hospital) faced discharge delays of at least three days after medical clearance in 2023. In Massachusetts, one in seven medical-surgical hospital beds were occupied by individuals who no longer needed hospital care between March 2022 and February 2023.[xx,xxi]

Delayed hospital discharges have negative impacts on individuals, caregivers, hospitals, payers, and communities. Individuals who remain in hospitals past their discharge date may experience delayed recovery, increased readmissions, and adverse health outcomes such as hospital acquired infections and reduced physical mobility.[xxii] In addition, extended hospital stays take a toll on individuals' mental health.[xxiii] Discharge challenges also impact hospitals by reducing capacity for new patients, leading to overcrowding, reduced access to needed care, and high costs.[xxiv] Without access to inpatient beds, some individuals will "board" in the emergency department for days or weeks. In California, extended hospital stays directly contribute to at least $3.25 billion in avoidable costs every year. These challenges and delays create health system inefficiencies and can lead to increased system costs.

To identify the root causes of the hospital discharge crisis, it is necessary to understand the post-discharge care continuum. Hospital patients with complex medical, behavioral health, LTSS, and social needs are often discharged to settings that may or may not be able to meet their unique combination of needs. **Figure 1** highlights common post-discharge destinations alongside key challenges.

Figure 1: Overview of Hospital Discharge Destinations

Discharge Destination	Example National Challenges
Home without Medicare Post-Acute Care	Many individuals are discharged home without the physical, financial, or cognitive ability to care for themselves. Unhoused individuals discharged "home" lack safe, stable housing to facilitate recovery.
Shelters and Medical Respite Care	Individuals who are unhoused may receive short-term housing or other social services in shelters. Most shelters are not equipped to support individuals with post-acute medical needs. Nationally, there are some medical respite programs available, but not enough to meet demand for services.[xxv]

National Data Insight

Nationally, Medicare FFS beneficiaries discharged to skilled nursing facilities have the highest hospital ALOS; on average, those discharged to skilled nursing facilities stay in the hospital more than twice as long as those discharged home.

- ATI analysis of 100% Medicare Part A FFS claims data, 2023Q3

Discharge Destination	Example National Challenges
Home with Home Health	Home health agencies provide critical services to assist patients with their recovery in the home, however, home health is a limited Medicare benefit that may not meet some individuals' medical, behavioral, and social needs.
Home with Home and Community Based Services (HCBS)	HCBS, whether funded privately or by Medicaid, can support individuals to return to the community. However, it can take months to be assessed for LTSS eligibility, and services may be difficult to access due to waitlists, insufficient access to providers, and other access constraints.
Skilled Nursing Facility (SNF) and Nursing Facility (NF)	SNFs serve as a critical source of short-term post-acute care for individuals needing daily skilled care. NFs provide LTSS for individuals in an institutional setting. However, workforce shortages and training challenges limit the number and types of patients SNFs and NFs accept, especially those with behavioral health needs.[xxvi]
Residential Settings[8]	Residential settings, such as adult foster homes, may be able to meet individuals' complex needs. However, demand exceeds supply of services, and payments may not reflect resources needed to care for individuals with complex needs.

Findings in this report should be contextualized against systemic challenges in ensuring timely and appropriate hospital discharge, including (1) limited post-acute provider and workforce capacity to provide the specialized and resource-intensive care needed to meet complex care needs, (2) rising medical, behavioral and social complexity of individuals awaiting discharge, (3) time-intensive functional and financial eligibility assessments to connect individuals with services post-discharge, and (4) post-acute care payment and coverage gaps.

QUALIFYING AND QUANTIFYING THE HOSPITAL DISCHARGE CRISIS IN OREGON

Oregon is experiencing similar challenges to states across the country in discharging patients from the hospital in a timely and appropriate manner. In Oregon, issues driving the hospital discharge crisis span systems and institutions beyond just healthcare, such as housing, social services, and education (specifically, postsecondary healthcare education shortages as presented to the Task Force by the Oregon Longitudinal Data Collaborative).[9]

Complex care needs may be associated with the steady increase in hospital ALOS in Oregon. Between 2017 and 2022, there were fewer hospitalizations (10% decrease), but there was an increase in ALOS (27% increase), which resulted in a 20 percent increase in the total number of hospital patient days. As **Figure 2** highlights, hospital patients with complex care needs, including frailty, Alzheimer's disease and related dementias (ADRD), and serious mental illness (SMI) experienced a greater increase in ALOS than the statewide average of 27 percent between 2017 and 2022. Our analysis indicates that discharge destination is also associated with ALOS; in Oregon, insured individuals with complex care diagnoses discharged to SNFs have experienced the greatest increase in ALOS from 2017 to 2022 (49%), suggesting that

8 In Oregon, a subset of these settings are referred to as Community-based Care (CBC) facilities. CBCs included assisted living, residential care, and memory care facilities. Additional detail on licensing for these settings can be found in the Oregon Department of Human Services (ODHS) CBC Compliance Framework Guide (link).

9 Additional information regarding the postsecondary healthcare education shorting in Oregon – and potential solutions to address it – can be found in the Oregon Longitudinal Data Collaborative's (OLDC) public presentation to the Task Force (link).

finding placement for individuals with complex care needs in certain settings may take longer than others.[xxvii] As discussed earlier, systemic issues beyond health care systems alone may be contributing to the increase in complexity.

Figure 2: Select Trends in the Average Hospital Length of Stay in Oregon, 2017-2022[xxviii]

Between 2017 and 2022, Oregon experienced:

27% Increase in Hospital ALOS

20% Increase in total hospital patient days

58% **of those discharged from the hospital had at least one complex care diagnosis.**

Between 2017 and 2022, the ALOS increased at different rates for people with certain complex care diagnoses:

Statewide	SMI	SUD	Housing Insecurity	Frailty	ADRD	Obesity
Changes in ALOS from 2017 to 2022						
▲ 27%	▲ 30%	▲ 28%	▲ 18%	▲ 48%	▲ 38%	▲ 29%
Average Hospital Length of Stay in 2022						
3.9 days	4.5 days	4.5 days	5.4 days	5.8 days	5.3 days	3.9 days

Between 2017 – 2022, the ALOS increased at different rates for people who discharged to certain destinations

49% **SNF**

41% **Home Health**

34% **Other**

19% **Home/Self Care**

Barriers to Timely and Appropriate Hospital Discharge for Individuals with Complex Care Needs

Understanding the barriers that hinder timely and appropriate hospital discharge is essential to addressing them. This section explores obstacles to timely hospital discharge in Oregon identified in ATI's research:

1. Staffing shortages, particularly in staff with specialized training and skills needed to care for individuals with complex care needs;
2. Lack of appropriate discharge destinations to meet growing patient complexity; and
3. Process-related challenges in assessing and connecting individuals with needed LTSS.

High-Level Data Sources Overview:

To better understand the specific challenges that Oregon's post-acute care providers are facing in caring for individuals with complex care needs, ATI conducted a series of interviews and a survey of providers across post-acute and long-term care, receiving 364 responses. ATI also conducted a quantitative analysis of Oregon's Healthcare Workforce Reporting Program data, AAA / APD service eligibility case manager data, All Payer All Claims Reporting Program database, and a literature review. The findings presented in this section are based on insights from these analyses. Detailed data sources and methods are provided in the **Appendix**.

BARRIER #1. POST-ACUTE CARE STAFFING SHORTAGES AND A LACK OF SPECIALIZED STAFF LIMIT THE ABILITY TO SERVE INDIVIDUALS WITH COMPLEX CARE NEEDS

Workforce limitations mean that post-acute care providers are not able to meet current demand for services. In part, these limitations derive from post-acute care settings competing for staff with higher-pay acute care settings or other industries and the need for staff with specialized experience.

Many post-acute care providers cannot meet current needs given severe staffing shortages. In ATI interviews and survey results, providers expressed not being able to meet any additional demand for post-acute care, for example, rehabilitation and recovery (please see ATI's High-Level Data Sources Overview for more detail). In large part, this is driven by a limited workforce. Nationally, between 2019 and 2022, SNFs lost more than one-fifth of their direct care workforce as the number of Certified Nursing Assistants (CNAs) and Licensed Practical Nurses / Licensed Vocational Nurses in this setting decreased.[xxix]

Post-acute care providers compete for workforce. Across the nation, the healthcare sector is experiencing workforce shortages across acute, post-acute, and preventative care settings.[xxx] Workers, including Registered Nurses (RNs) and CNAs, generally make higher wages in the hospital setting compared to a post-acute care setting. In Oregon, RNs working in the hospital setting make 17 percent more than those in residential care facilities and 14 percent more than those in SNFs.[xxxi] RNs employed in post-acute care settings are more likely to have an Associate degree in lieu of a Bachelor's (46% of RNs compared to 24% in the hospital setting) and are more likely to be further along in their career (average license held 3.3 years longer than in the hospital setting).[xxxii] For entry-level healthcare workers without advanced degrees, post-acute care providers compete with other industries offering higher wages.[xxxiii]

Providers need specialized staffing and resources to serve those with behavioral health and other complex care needs. Post-acute care providers identified behavioral health specialists as the largest staffing gap in serving individuals with complex care needs. Over a third of post-acute care providers surveyed reported that adding behavioral health specialist(s) to their organization would be helpful in serving individuals with complex care needs (38% reported mental health counselors would be helpful, while 26% and 23% reported psychologists and Substance Use Disorder (SUD) specialists respectively would be helpful).[xxxiv]

BARRIER #2. GROWING PATIENT COMPLEXITY STRAINS PROVIDER ABILITY TO MEET DEMAND FOR SERVICES

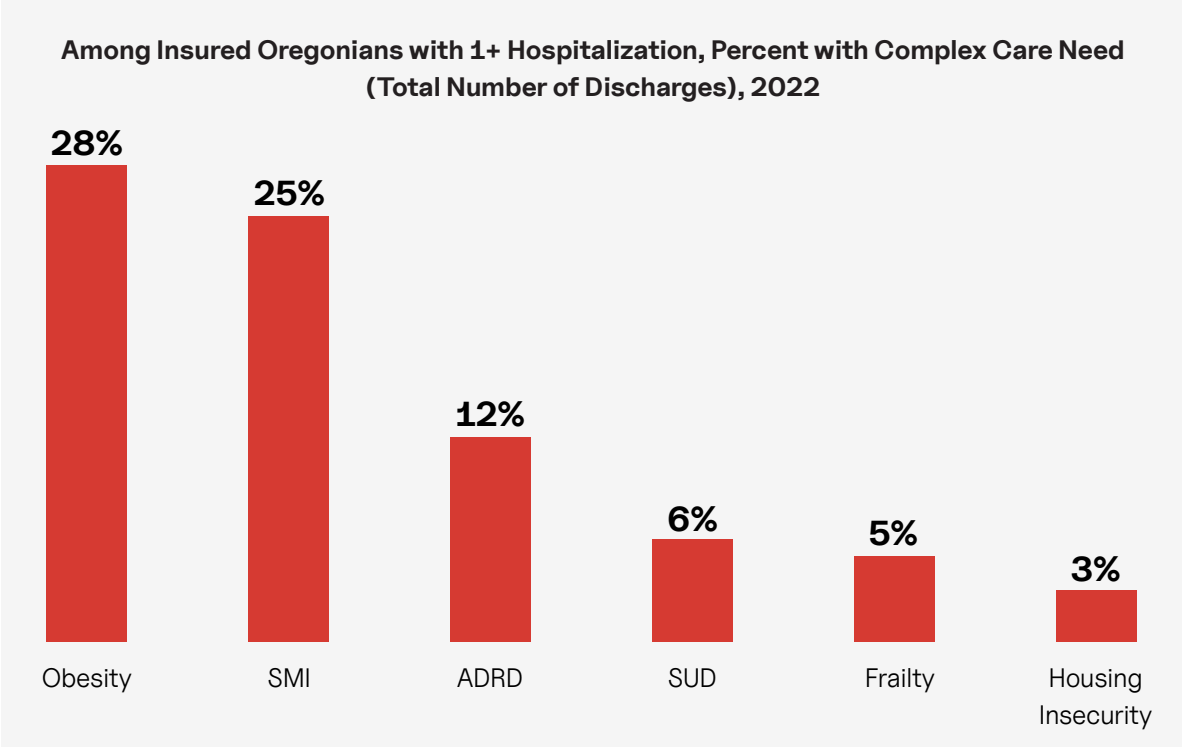
Post-acute care providers can benefit from additional staffing and resources when individuals have complex and co-occurring medical and social needs. Similarly, AAA / APD case manager staff who conduct Medicaid LTSS screening and eligibility determinations and secure post-discharge placement, could benefit from additional resources and capacity to find a placement that meets the individual's level of care needs. Stakeholders perceive inadequate payment policies and a punitive (rather than collaborative) state regulatory framework as further compounding these barriers, as identified through ATI's provider survey and interviews.

Nationally and in Oregon, limits on post-acute provider capabilities are influenced by increasing patient complexity. In Oregon in 2022, more than half of individuals discharged from the hospital had at least one complex care need ranging from obesity, SMI, ADRD, SUD, frailty, or housing insecurity.[xxxv] These conditions and needs impact the kind of post-acute care individuals require to be safely discharged. For example, among those with SMI who were hospitalized in Oregon in 2022, over half (52%) were older than age 65 and were more likely to have co-occurring needs (e.g., having both SMI and housing insecurity), as compared to individuals with other complex care needs in **Figure 3**.[xxxvi] This points to the importance of considering the intersection of behavioral health and complex care needs within post-acute care settings serving older adults.

While more than half of individuals discharged from the hospital had at least one complex care need in Oregon in 2022, a relatively small number of individuals with complex care needs discharge to a given facility at a given time. Without economies of scale, it can be financially and administratively infeasible for providers to invest in the capabilities, resources, and staffing necessary to appropriately serve these individuals in accordance with minimum level of care

and resident protection requirements set by federal and state regulators. A common theme voiced by Oregon stakeholders through ATI's survey, interviews, and Task Force meetings is that Oregon's current regulatory and payment environment for facility-based post-acute care providers – particularly SNFs – limits their ability to pursue the more resource-intensive staffing and supports necessary to care for individuals with complex care needs. This suggests that supporting post-acute care settings that can specialize in meeting key complex care needs at scale could alleviate shortages.

Figure 3: Diagnoses of Individuals Discharged from the Hospital Among Oregonians with One or More Hospitalization(s)[xxxvii]



Payment is insufficient for community-based LTSS providers to provide quality care for individuals with complex care needs, as reported in ATI's provider survey and in interviews. Community-based residential care settings, such as assisted living facilities (ALFs), residential care facilities (RCFs), and Adult Foster Homes (AFHs), can be appropriate care settings for many Oregonians with complex care needs, particularly for older adults and people with disabilities. In particular, survey respondents and interviewees emphasized the essential role of AFHs in serving these individuals. Of all providers responding to ATI's March 2024 survey, AFHs reported the lowest rates of having problems accepting individuals with a variety of complex care needs (e.g., housing insecurity, complex medical needs) in the last month.[10]

10 This question was phrased: "In the last month, did your organization have any problems when trying to accept individuals with the following needs?" Respondents included NFs, RCFs, ALFs, APD AFHs, behavioral health AHFs, in-home care agencies, dialysis centers, home health agencies, and hospice. IDD AFHs were not surveyed, as ATI's survey included only providers licensed by either OHA or ODHS.

Further, key stakeholders (including hospitals, state agencies, and CCOs) consistently shared in interviews with ATI that AFHs are most readily willing to accept individuals with complex care needs from hospitals. However, according to AFHs surveyed by ATI, insufficient payments create challenges for a large share of AFHs, more so than any other provider type surveyed.

Within AFHs, payment rates vary substantially between the populations they are licensed to serve (i.e., older adults and adults with physical disabilities; adults with behavioral health needs; adults with intellectual and/or developmental disabilities).[11] AFHs may serve individuals outside of their licensure and are paid based on the eligibility type of the individual. There are payment variations based on patient need, but providers interviewed by ATI (both AFH and non-AFH), Task Force members, and APD do not believe these payment variations reflect the resources required to care for individuals with complex care needs. AFHs licensed by APD can contract to provide special needs care at higher rates or request rate exceptions, however AFHs and state agencies reported that these processes are burdensome and insufficient to meet individuals' complex care needs.

63%

of adult foster homes surveyed disagreed or strongly disagreed that payments sufficiently covered care for individuals with complex care needs.

While AFHs reported insufficient payment as a barrier most frequently compared to other surveyed providers, other post-acute providers in Oregon also perceived overall payment as insufficient to cover costs for complex care delivery. Half of providers surveyed by ATI disagreed with the statement that, in general, payments sufficiently covered care for complex care need individuals. Perceptions of payment adequacy for individuals with less complex needs profiles varied among provider types, with SNFs generally relaying that payment is reasonable and AFHs largely sharing that payment is insufficient.

The AAA / APD case managers conducting the financial and functional eligibility assessments to connect individuals with LTSS upon hospital discharge face workforce challenges. AAA / APD case managers responsible for functional and financial eligibility assessments for LTSS are critical to promoting timely discharge, particularly for individuals with LTSS needs (please see more detail on the role of AAA / APD case managers in the **Key Terms and Coverage Snapshot** section of the report). ATI's analysis found that AAA / APD case manager wages have been falling behind wages in other occupations and inflation – case manager wages grew 5 percent from 2021 to 2023, compared to 7 percent for all Oregonian workers and 12 percent for all community and social service occupations (inflation increased 12%).[xxxviii] In addition to increased wages competition, care managers reported experiencing increased workloads. Specifically, many reported an increase in the complexity of the medical, behavioral, and social needs in the individuals they support. One challenge in understanding workload is that the current caseload methodology does not reflect the true volume of case work. This is because individuals who receive case manager services but who are not currently placed in a AAA / APD care setting are not "counted" towards an individual case manager's caseload.[12]

"

"I saw something that said caseload per manager is 66 and I felt sick to my stomach. It is actually 100 to 110. It was brutal in underrepresenting [the true caseload]."

– Oregon AAA Case Manager

11 Additional information regarding differing payment rates across the different populations AFHs serve can be found in ATI's public presentation to the Task Force (link).

12 In ATI interviews, ODHS APD staff shared that efforts are currently underway to count all cases, regardless of paid provider status, to more accurately reflect the actual volume of work case managers undertake. These efforts are described in more detail in OHA's / ODHS's publicly posted materials for the July Task Force meeting (link).

BARRIER #3. COMPLEX LTSS ELIGIBILITY DETERMINATIONS AND GUARDIANSHIP ACCESS CAN DELAY DISCHARGES

For individuals requiring support with activities of daily living, successful hospital discharge depends upon establishing coverage for and accessing appropriate LTSS. Medicaid LTSS determinations and insufficient access to guardians can lead to delayed hospital discharge to the appropriate setting.

Medicaid LTSS determinations can delay the discharge process. Applying for Medicaid LTSS benefits is a complex, time-intensive process that can be hard to navigate, often requires detailed documentation, and can span multiple agencies. Once determined to be eligible, individuals can face challenges finding providers and services, which can further delay safe hospital discharge. For example, according to ATI analysis, many Oregonians have both functional needs as well as behavioral health needs. This can sometimes make it unclear to hospital discharge planning and state case management staff which Medicaid 1915 services and screening processes to pursue, i.e., the OHA-administered 1915(i) or the APD / AAA-administered 1915(c) and 1915(k) pathways. Even with the right screening and eligibility pathway identified, there remains the challenge of finding an available provider that is willing and able to serve that individual.[13] Interviewees indicated that obtaining 1915(i) services can be challenging because Oregon targets their 1915(i) benefit to those with a chronic mental illness diagnosis and a need for daily assistance due to mental health needs, as determined by a third-party clinical reviewer. For those who qualify, it can be challenging to find providers available to serve intensive behavioral health needs and challenging behaviors. Therefore, according to interviewees, hospital discharge planners are more inclined to guide clients toward the AAA / APD eligibility pathways, even if the individual is ultimately denied eligibility because of their mental health needs. Further, interviewees shared that hospital discharge planning staff are typically not aware of all the discharge options and the capabilities that providers may have in place through innovative partnerships with social service providers, CCOs, or D-SNPs.

Further, connections to LTSS require both functional and financial Medicaid eligibility determinations. Even when the functional eligibility determination is successful, the financial eligibility assessment process (administered and managed by the Oregon Eligibility Partnership[14]) is inherently long and can be extended further by delays. Federal requirements mandate that eligibility determinations happen within 90 days for applicants who apply on the basis of disability and 45 days for all other applicants.[xxxix] The Oregon Eligibility Partnership currently manages the financial eligibility assessment process for Medicaid and other programs.[xl] Interviews revealed that local AAA and APD staff face challenges with this centralized system, especially when seeking information or to intervene to help an application progress.

Oregon's Shared Accountability Approach to LTSS

Under Oregon's shared accountability model for LTSS administration and delivery, CCOs are responsible for referring their members who need or use LTSS (institutional or HCBS) to regional or county AAAs / APD. Local AAAs / APDs manage and monitor most LTSS, including eligibility determinations and authorizations. CCOs are required to develop an MOU with AAAs / APD to guide coordination and alignment between LTSS local offices and CCOs.

13 Oregon's 1915(i) provides home-based habilitation, behavioral health habilitation and psychosocial habilitation services to individuals 21 years or older with a chronic mental illness diagnosis. Additional information regarding the 1915(i) and other Medicaid 1915 waivers can be found in OHA's / ODHS's July presentation to the Task Force (link).

14 Additional information on the Oregon Eligibility Partnership and its role in Medicaid financial eligibility determinations can be found on the OHA website (link).

Guardianship and healthcare proxy decisions can exacerbate delays. When an adult is incapable of making decisions necessary for their basic care and safety and no one (next of kin or otherwise) is available to represent the individual, a public guardian may be required. ATI's survey and interviews revealed a shortage of guardians in the Oregon Public Guardian program relative to the demand. This shortage of guardians can contribute to delays in discharge when a guardian is needed to make decisions related to applying for Medicaid eligibility or post-discharge care setting. Legal processes resolving guardianship, conservatorship, and healthcare proxy cases involve filing petitions, attending hearings, and waiting for court decisions. These processes can take months, leaving patients in hospitals long after they are ready for discharge.

Policy Opportunities to Promote Timely and Appropriate Hospital Discharge for Individuals with Complex Care Needs

The state legislature, state agencies, healthcare and social services industry, and CMS can support timely and appropriate hospital discharges for individuals with complex care needs. Ultimately, ensuring that individuals – regardless of insurance coverage type – are discharged to the appropriate setting with the right level of post-discharge supports will require initiatives across the care continuum. Given the Task Force's focus on Oregon administrative and legislative recommendations, as directed by HB3396, this section provides detailed discussion on state opportunity areas, particularly within the state's legislative capacity and administrative and contractual influence over Medicaid across OHA and ODHS.[xvii] ATI also provides a menu of approaches for Oregon's industry and CMS partners.

In 2022, the OHP covered one in three (31%) hospital stays, with Medicare covering nearly one in two (49%), and commercial carriers covering one in five (20%). Oregon can influence hospital discharges through its existing Medicaid and Medicare D-SNP levers of influence.

- ATI analysis of Oregon All Payer All Claims data, 2022

STATE OPPORTUNITIES

Oregon has a variety of levers to support individuals in accessing needed post-acute care in the most appropriate setting. The Medicaid program can impact payments to key post-acute care providers, wages for direct care workers, coverage of key care settings, and streamlined LTSS eligibility processes in ways that increase the system's capacity to care for individuals with complex care needs. Notably, the state can leverage existing federal Medicaid managed care authority with its CCOs and their affiliated D-SNPs, and its shared accountability approach to financing and delivering LTSS to promote timely and appropriate hospital discharges (please see the **Key Terms and Coverage Snapshot** section of this report for more detail on these state levers).

Some state opportunities could be pursued under existing Medicaid authority and CCO / D-SNP infrastructure. Others would require new CMS and / or state authority (**Figure 4**). Taken together, these opportunities can alleviate pressure points within the system to enable more timely and appropriate hospital discharges for individuals with complex care needs.

Figure 4: Overview of State Opportunities to Increase Timely and Appropriate Hospital Discharges

Opportunity	Allowable within Existing State Medicaid Flexibilities and Delivery System	Ability to Leverage and Refine Existing Contractual Expectations of CCOs / D-SNPs	Likely Requires New Federal Medicaid Authority via CMS Approval
State Opportunity Area #1: Supporting Providers in Developing Capacity and Skills to Serve Individuals with Complex Care Needs			
Increase Direct Care Worker Wages	X		
Increase Direct Care Worker Training Opportunities	X		
Create New Direct Care Worker Certification Opportunities	X		
Modify the Payment Methodology for Adult Foster Homes	X		
Leverage Value-Based Purchasing (VBP) Strategies	X	X	
State Opportunity Area #2: Driving Innovation through New or Expanded Benefits and Coverage			
Provide Medicaid Coverage for Medical Respite and Recuperative Care			X[15]
Enable Specialized, Facility-Based Care Delivery Models to Serve Individuals with Complex Needs	X		
State Opportunity Area #3: Streamlining the Hospital Discharge and Medicaid Eligibility Processes			
Enhance Communication and Coordination Before Discharge	X	X	
Streamline Medicaid LTSS Eligibility			X
Enhance Care Management and Coordination	X	X	

15 Authorizing medical respite via a Section 1115 demonstration is the most expansive pathway to achieving statewide access, while affording the state opportunity to receive federal Medicaid matching funds for the provision of room and board. However, ATI discusses opportunities for Oregon to promote medical respite via existing Medicaid flexibilities in **State Opportunity Area #2** and **Industry Opportunities** sections of this report.

STATE OPPORTUNITY AREA #1. SUPPORTING PROVIDERS IN DEVELOPING CAPACITY AND SKILLS TO SERVE INDIVIDUALS WITH COMPLEX CARE NEEDS

Payment policies, as well as training and certification programs, can support providers to improve workforce recruitment and retention and bolster capabilities to address the needs of individuals with complex needs.

INCREASE DIRECT CARE WORKER WAGES

ATI's analysis of OHA's Healthcare Workforce Reporting Program data found that post-acute care workers are seeking more hours, and many provider interviewees (e.g., in-home care, SNF, and home health) raised the issue of insufficient wages as a key challenge in recruiting and retaining these post-acute care workers.[xli] Wage passthrough requirements associated with the current Medicaid base rate or enhanced payments are one way to influence direct care worker wages. Oregon is conducting a rate and wage study concurrent with the Task Force's work, which should be used to inform whether wage passthroughs are achieved through existing or enhanced rates.

During the COVID-19 pandemic, Oregon implemented a 10% wage-add on increase to the Medicaid rate for ALF, RCF, Memory Care Facilities, and In-Home agencies. The wage-add on increase was effective from October 1, 2021, through June 30, 2023 and required HCBS providers to increase CNA wages from $15.00 per hour to $15.50 per hour, initially.[xlii] For NFs, CNA wages were increased from $17.00 to $17.50 per hour.[xliii]

Other states have used a variety of Medicaid approaches to increase direct care worker wages. For instance, Minnesota has longstanding wage passthrough requirements for direct care workers. It has historically leveraged a percentage passthrough approach, which requires agencies to use 72.5 percent of the revenue generated by Medicaid payments for community first services and supports to support worker wages and benefits.[xliv] Minnesota also provides additional funding to providers when their care workers complete certification and training programs. Direct care workers who work with Personal Care Assistance (PCA) Choice, Consumer-Directed Community Supports (CDCS), or Consumer Support Grant (CGSG) programs and complete qualifying trainings can receive a $500 stipend. PCA, CDCS, and CDSG provider agencies are reimbursed at a 7.5 percent higher rate when their care workers have completed qualifying training.[xlv] Finally, Minnesota also has a value-based reimbursement policy for nursing facilities. Under this system, nursing facilities that meet quality goals are reimbursed for the total sum of wages, rather than the portion of the costs they would have previously received. Early data suggests that direct care worker wages increased following implementation of this program.[xlvi]

Implementation Consideration

In a May 2024 Medicaid final rule (the Ensuring Medicaid Access final rule)[xlvii], CMS set a new requirement that 80 percent of Medicaid payments for homemaker, home health aide, and personal care services be spent on compensation for direct care workers furnishing these services. This is higher than the rate that some states set for their wage passthrough (e.g., Minnesota sets it at 72.5%) and is intended to encourage states to further improve compensation for care workers. CMS extended the timeframe for states to comply with the 80% performance level from four to six years in the final rule.

States may also have some flexibility to apply a different percentage to small providers or exempt providers that may experience hardship from meeting the set performance level. However, it is too early to tell the degree to which CMS will grant states flexibility as this rule provision is implemented.

Concurrent with the Task Force's work, ODHS is conducting a Wage and Rate study with the goal of informing Medicaid reimbursement rates for providers paid for by ODHS-APD and the Office of Developmental Disabilities Services.[xlviii] These ODHS survey findings can be used to inform future State Medicaid rate adjustments and associated wage policies.

INCREASE DIRECT CARE WORKER TRAINING OPPORTUNITIES

Through a survey and interviews with post-acute care providers, ATI found that providers in Oregon are experiencing direct care workforce shortages. Increasing the pipeline of direct care workers can enable providers to accept more individuals being discharged from the hospital.

Supporting opportunities for training direct care workers is essential to building this pipeline.. States have implemented a variety of programs like apprenticeships and partnerships with educational institutions to create opportunities to enter the workforce. A CNA apprenticeship program currently operates in Oregon, run by Long-Term CareWorks with partners including the state's largest care provider union and four SNF providers.[xlix] This program allows participants to receive paid skills training and classroom instruction. Investments and participation in this or a similar program could be expanded to support additional CNA training. There are several potential opportunities for Oregon to support such an expansion.

- → Federal or state funds could support additional apprenticeship positions. For example, the Apprenticeship Building America program has provided for several rounds of funding to state and local agencies, workforce development boards, CBOs and others to leverage Registered Apprenticeship as a workforce solution in high-demand sectors such as the care economy.[l]
- → New supports for apprentices could enable more individuals to enter the program. For example, the federal Health Professionals Opportunities Grant (HPOG), provided supportive services (such as childcare and transportation) alongside healthcare education and training to help participants overcome barriers to employment.[li]

Additionally, apprenticeship programs can support training for other types of workers beyond CNAs, such as personal care aides, home health aides, and licensed practical nurses (LPNs). Investment in additional apprenticeship programs in Oregon could be targeted to one of these or other positions.

- → The QuILTSS Institute Direct Service Professionals (DSP) Apprenticeship Program in Tennessee provides apprenticeships through a public private partnership that engages state agencies, a Medicaid MCO, and providers. Apprentices receive training in providing LTSS, especially for those with intellectual and developmental disabilities.[lii]

- Washington's Workforce Board, State Board of Nursing and Department of Labor and Industries plans to establish a Licensed Practical Nurse Registered Apprenticeship Program. Employers and community colleges are also partners.[liii]
- The Massachusetts legislature has passed a bill that would create a Long-Term Workforce and Capital Fund for workforce training programs for new CNAs, a CNA-to-LPN pathway, and supervisory training for clinicians.[liv]

CREATE NEW DIRECT CARE WORKER CERTIFICATION OPPORTUNITIES

Providers also noted that their staff often lack the specialized training necessary to meet complex care needs. Specialized training and certification can enable providers to appropriately care for individuals with complex care needs upon hospital discharge.

Certification programs for advanced aide roles allow direct care workers to gain the skills needed to provide quality care to individuals with complex care needs in existing settings, while also providing opportunities for career advancement. Certifications can focus on caring for individuals with particular complex care needs such as behavioral health issues or be more broadly applicable for care of all populations. Several states have pursued innovative training and certification opportunities focused on advanced or specialized training for direct care workers:

State Spotlight: Complex Care Training and Certification Opportunities

New York. Through an Advanced Home Health Aide program, aides are allowed to perform advanced tasks with appropriate training and upon assignment and supervision by registered nurses.[lv]

Alaska, Colorado, and Tribal Health Organizations. These states and Tribal Health Organizations are piloting and implementing behavioral health aide models, which train and certify community leaders to work as members of behavioral health care teams.[lvi,lvii] Additionally, Alaska established an apprenticeship program focused on dementia for CNAs in six state-run ALFs in 2016, and as of 2021 approximately 20 percent of CNAs in these facilities had completed the training.[lviii]

Massachusetts. Under legislation passed by the Massachusetts legislature, SNFs would be required to create a Certified Medication Aide Role for CNAs that would allow them to dispense non-narcotic medications to residents.

With a larger pipeline of direct care workers and specialized training, Oregon providers may be able to accept and care for more individuals who have complex care needs. These opportunities can be considered in combination with wage enhancements and specialized care settings discussed elsewhere in this report. They can work in combination to bolster providers' ability to care for individuals with complex care needs, the size of the workforce, and job specialization.

MODIFY THE PAYMENT METHODOLOGY FOR ADULT FOSTER HOMES

ATI's survey and interviews revealed that (1) AFHs play a critical role in the care continuum for individuals with complex care needs, and (2) stakeholders believe increased AFH capacity would help to increase timeliness of hospital discharges. However, stakeholders emphasized that insufficient and inconsistent payment to AFHs is a barrier to greater capacity.

A key opportunity for Oregon to expand AFH capacity is to increase and standardize rates according to severity of the individual's care needs. Oregon's legislature has considered legislation, House Bill 2495 introduced in the 2023 regular session, to modify AFH payment rates.[lix] This bill did not pass but would have directed ODHS to restructure AFH payments to (1) increase base rates and add-on payments by 50 percent until a restructured methodology is in place and (2) adopt restructured acuity-based rates to reduce the need for exceptional payments. Other states, such as Washington State, may also serve as a model for revised payment methodologies.

State Spotlight: Acuity-Based Payment Rates for AFHs

Washington. Pays AFHs based on 17 unique classification groups that reflect levels of resources required to care for clients. State case managers evaluate clients using the Comprehensive Assessment Reporting Evaluation (CARE) 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.[lx]

LEVERAGE VALUE-BASED PURCHASING (VBP) STRATEGIES

Post-acute care providers who responded to ATI's survey indicated that payment rates for individuals with complex care needs are insufficient and do not reflect the resources required to provide high quality care. Oregon could consider advancing Medicaid add-on or incentive payments for post-acute and LTSS providers to offer high-quality care that meets the needs of individuals with complex care needs.

Oregon has an existing Value-Based Payment Roadmap for CCOs, which includes a four-year plan with a final target of 70 percent of CCO payments in the form of VBP by 2024. In mid-2023 most CCOs expressed confidence about meeting the 2023 requirement of 60 percent of payments made through VBP.[lxi] However, post-acute care is not currently a focus of these efforts. Oregon could require or encourage CCOs to build VBP relationships with SNFs and other post-acute care providers. As of 2021, there were 30 nursing home Medicaid VBP programs in 24 states.[lxii]

While CCOs could pursue VBP for post-acute care, LTSS is carved out of CCO contracts and covered by ODHS and OHA. These agencies could consider modifying their fee-for-service LTSS payment methodologies to incorporate VBP. A variety of states have designed, planned, and implemented VBP for LTSS providers. As of November 2021, 20 states and D.C. had implemented an LTSS alternative payment model for NFs, typically pay-for-performance models with payment incentives for meeting quality measures.[lxiii]

Potential measures that could support hospital discharge goals in both post-acute and LTSS VBP programs include workforce recruitment, training and retention; access to and timeliness of care; and complex care availability; and clinical or quality of life outcomes.[lxiv] For example, Oregon could provide payment incentives to post-acute and LTSS providers for enhanced care management for individuals with behavioral health needs.

STATE OPPORTUNITY AREA #2. DRIVING INNOVATION THROUGH NEW OR EXPANDED SETTINGS AND COVERAGE

Interviewees across Oregon's care continuum and Task Force members have underscored the need for new or expanded care settings to meet the complex care needs of individuals experiencing hospital discharge delays. In particular, stakeholders reported a lack of appropriate care settings for unhoused individuals and individuals with cooccurring physical and behavioral health needs. Oregon can address this issue through (1) Medicaid coverage of certain new care settings and (2) providing technical support to existing settings to enhance their capacity to meet these needs.

PROVIDE MEDICAID COVERAGE FOR MEDICAL RESPITE AND RECUPERATIVE CARE

Interviewees and survey respondents indicated that increased access to medical respite care would fill a gap in the care continuum in Oregon by meeting the needs of unhoused individuals facing delayed hospital discharges. Medical respite provides continuing care options following acute and post-acute care for unhoused individuals who are too ill or frail to recover from a physical illness or injury, but not sick enough to be in a hospital. Medical respite helps bridge the gap between hospitals and homeless shelters or other housing providers, which typically lack the capacity and licensing to provide medical and support services during the recuperative period. In Oregon, individuals facing housing insecurity had the highest rate of ED visits of the groups studied (an average of 4.8 visits, compared to statewide 1.7 visits). Medical respite models can reduce hospital readmissions, ED visits, and lengths of stay while providing unhoused individuals a place to continue recovery after discharge.[lxv,lxvi]

Several medical respite providers and funding streams already exist in Oregon. For example, Project Turnkey 2.0 grant funding has supported new medical respite beds and CCOs have invested in medical respite providers and services through HRS and other CCO flexible spending initiatives (discussed further below and in the **Key Terms and Coverage Snapshot** section of this report).[lxvii] However, medical respite is not currently included in OHP as a covered Medicaid service, meaning it is provided at the CCOs' discretion and not available to all individuals with Medicaid coverage. Oregon can encourage utilization and expansion of medical respite through existing Medicaid flexibilities as well as authorities that would require new CMS approval (e.g., Section 1115 demonstration authority).

Under existing Medicaid flexibilities, OHA can promote use of medical respite to support appropriate hospital discharges through the following:

→ **CCO Contracts:** Strengthen requirements for CCOs to work with medical respite providers, such as through developing referral processes and contractual relationships, and

Federal Policy Impact

Finding a hospital discharge location can be especially challenging for unhoused individuals because federal rules for SNF participation in Medicare and Medicaid include expectations for safe discharge. SNF providers may not be willing or able to accept unhoused individuals without assurance of a safe post-SNF discharge option in place. Medical respite and recuperative care can enable SNFs to serve more unhoused individuals by providing a safe discharge destination for post-SNF care.

requiring a designated point of contact such as New Jersey's requirement for Medicaid managed care entities to have a housing specialist on staff.

→ **Strengthening SHARE Initiative Guidance:** The Supporting Health for All through REinvestment (SHARE) Initiative is a legislatively-enacted requirement for CCOs to reinvest a portion of their profits in their communities toward upstream non-healthcare factors that impact health, such as housing, food, transportation, or other social determinants of health and equity.[lxviii] While housing is currently an eligible SHARE initiative, Oregon could institute more prescriptive reinvestment requirements mandating investments in housing or medical respite care, such as requiring a set percentage of profits be designated for medical respite programs.

Oregon can also explore opportunities to expand access to medical respite through new authorities.[16] A Section 1115 demonstration is the primary vehicle to make medical respite a statewide, Medicaid-covered benefit while optimizing federal Medicaid match for the provision of room and board. This could be accomplished through (1) an amendment to the state's existing demonstration, or (2) inclusion in Oregon's 2028 1115 demonstration renewal request.

A Section 1115 demonstration is the primary vehicle to make medical respite a statewide, Medicaid-covered benefit while optimizing federal Medicaid match for the provision of room and board. This could be accomplished through (1) an amendment to the state's existing demonstration, or (2) inclusion in Oregon's 2028 1115 demonstration renewal request.

ENABLE SPECIALIZED, FACILITY-BASED CARE DELIVERY MODELS TO SERVE INDIVIDUALS WITH COMPLEX NEEDS

Interviewees, survey respondents, and Task Force members representing provider perspectives identified Oregon's current regulatory and payment environment as limiting to existing providers' ability to invest in the staffing and supports required to meet complex care needs.

Oregon currently has several programs that support specialized capabilities among post-acute providers. The Oregon Enhanced Care Services program, a collaborative partnership between OHA and ODHS-APD, is one specialized care delivery model that may enable facility-based providers to invest in the clinical, staffing, and other resources needed to effectively meet the needs of individuals with complex care needs. Specifically, the Enhanced Care Services program allows for special contracts in select settings such as SNFs for Enhanced Care Facilities to serve individuals with complex behavioral health needs who require post-acute care.[lxix] Another relevant model is Specific Needs Contracts, which allow Oregon AFHs, RCFs, and ALFs to apply to reserve a set number of beds for individuals with particular service needs that exceed those encompassed in the base payment and add-ons, such as dementia.[lxx] These providers receive a higher payment rate for care provided to those individuals.[lxxi]

However, interviews revealed that these programs have not created sufficient capacity to date. For example, current Enhanced Care Facility availability and resources are limited, with only eight Enhanced Care Facilities operating in six of Oregon's thirty-six counties. Expanding state investments in elective programs that supports SNFs and community-based providers could incentivize development of the expertise and experience needed to provide high-quality care.

16 Additional detail on varying state approaches to pursuing medical respite and recuperative care via Section 1115 demonstrations and other Medicaid authorities". Otherwise the sentence can continue as is provided in ATI's July 2024 presentation to the Task Force (link).

To encourage expansion, Oregon could consider financial incentives or free training to providers that participate. The state could also facilitate connections to specialized workforce programs, such as those discussed in **Opportunity Area #1**.

There has also been federal recognition of the need for behavioral health expertise in post-acute care, with the establishment of the Center of Excellence for Behavioral Health in Nursing Facilities offering training, technical assistance, and other resources. Oregon can leverage these additional resources in supporting facilities to provide quality care to individuals with complex care needs.[lxxii] Hospitals, CCOs, and ODHS-APD can work with the Enhanced Care Facility program to leverage enhanced behavioral health capabilities and direct appropriate patients to these providers.

In addition to specialized training and contracts, Oregon's provider licensing and survey agencies could consider enhancing educational opportunities that support providers in maintaining compliance with state and federal conditions of participation. A non-punitive quality improvement approach that provides practical support to facilities willing to accept individuals with complex care needs could help reduce the sense of regulatory risk. For example, Washington State offers a Long-Term Care Quality Improvement Program, which provides education, coaching and support to NF and other providers to strengthen providers' systems, improve compliance with facility regulations, and prevent harm to vulnerable individuals.[lxxiii]

"[Regulatory] rules and policies make it so we can't help certain people due to the risk, but there is nowhere for them to go . . . the policies set us up to fail. . . we keep trying to make our current system work for some of these residents, and it's just not made for everyone. We need specialized facilities with a different set of rules, and more supports in place to address the needs of the more complex residents."

- Survey Respondent

STATE OPPORTUNITY AREA #3. STREAMLINING THE HOSPITAL DISCHARGE AND MEDICAID ELIGIBILITY PROCESSES

In addition to supporting additional capacity-enhancing opportunities among post-acute care providers, Oregon can pursue opportunities to improve the processes related to patient discharge, including (1) the connections between hospitals, state and local agencies, CCOs, D-SNPs and providers when preparing for discharge and (2) financial and functional eligibility processes for Medicaid LTSS.

ENHANCE COMMUNICATION AND COORDINATION BEFORE DISCHARGE

Through provider survey responses and interviews, ATI found that breakdowns in communication and coordination between hospitals, state agencies, CCOs, D-SNPs, and other healthcare providers contribute to patient discharge delays. At the request of the Task Force, ATI conducted further research to explore how implementation of an escalation protocol may support providers, state agencies, and CCOs / D-SNPs to more effectively and proactively coordinate to address discharge delays. An escalation protocol prescribes a clear process for communication between hospitals and other providers, state agencies, and CCOs / D-SNPs to elevate cases of delayed discharge. Such a protocol requires an infrastructure and a process to facilitate this communication and subsequent follow-up. Key participants in a protocol effort may include hospitals, state agencies (such as ODHS, APD, OHA, and Oregon Eligibility Partnership), CCOs / D-SNPs, post-acute and LTSS providers, primary care providers, and social services providers. The preferences of individuals and their caregivers must remain central in such a process.

Possible components of an escalation protocol include triggers for use (typically patient characteristics or identified risks for discharge delay), a system for sharing case information with appropriate processes for protected health information, regular meetings of relevant stakeholders to review current cases, and follow-up actions and accountability. CCOs are currently required to have an MOU with APD and AAAs related to coordinated care planning and care transitions *(*please see the **Key Terms and Coverage Snapshot** section of this report for more detail on MOUs*)*, and hospitals may have ad hoc connections with APD, AAAs, or other state agencies. However, interviews revealed that these existing communications have been insufficient to resolve discharge delays for a variety of reasons, such as lacking the right individuals at the table or inconsistent follow-up.

While there is no standard escalation protocol structure, some states have implemented agency-staffed discharge support teams and phone lines that hospitals may contact for support with LTSS and housing discharge challenges.[lxxiv]

Definition

An escalation protocol is a process by which hospitals can communicate with other providers, state agencies, and CCOs / D-SNPs to elevate individual cases where a patient's discharge has been delayed (or a delay is anticipated).

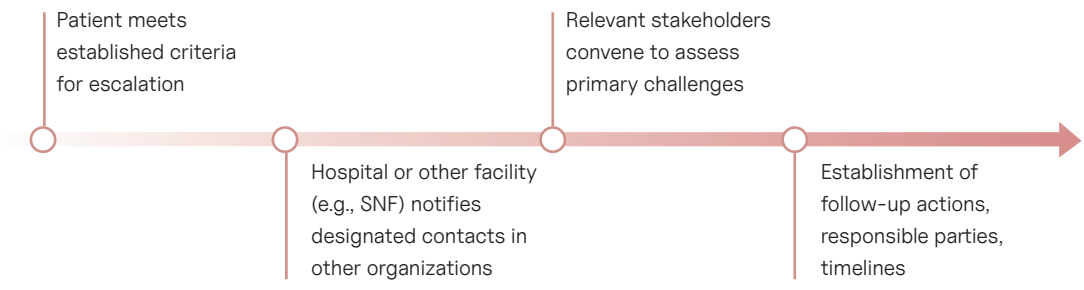
State Spotlights: Escalation Protocol Approaches

Washington. Provides a variety of supports, including case management, for discharges and placement of individuals who are unhoused, have mental health or substance use issues, require guardianship services, do not have access to traditional health insurance, or have specialized medical care needs.

Massachusetts. Uses a Discharge Support Team / Line to support with long-term care and housing discharge challenges, especially for patients with skilled nursing needs and who are unhoused or housing unstable.

Given the varying geographic footprints of key stakeholders such as hospitals and health systems, other providers, agencies, and CCOs, a regional escalation protocol structure is likely to be most effective. Regional conveners accountable for bringing stakeholders together and serving as the administrative lead for an escalation protocol could facilitate greater efficiency in the discharge process and ultimately more timely placements with necessary supports in place (**Figure 5**). Such a convening could be required through CCO / D-SNP contracts or agency direction and could leverage existing local infrastructure to ensure the protocol is well-suited to the agencies, providers, and other stakeholders in a given region. CCOs / D-SNPs could convene regional groups based on their current coverage areas. Alternatively, AAAs or APD could convene regional groups based on their existing district map.

Figure 5: Example of a Possible Escalation Protocol that Requires Coordination Across Providers and Stakeholders



STREAMLINE MEDICAID LTSS ELIGIBILITY

In response to requests from the Task Force, ATI researched opportunities to expedite Medicaid eligibility processes for individuals needing LTSS. The length of eligibility assessment processes for LTSS, including financial eligibility determinations, contributes to discharge delays for older adults and individuals with disabilities. These individuals are typically part of federal, non-Modified Adjusted Gross Income (MAGI) Medicaid eligibility groups which makes eligibility determination more complex and time-intensive.[17] While these processes inherently require time to complete, opportunities exist to provide temporary eligibility for individuals more quickly or reduce the assessment requirements to expedite the process. As noted in **Figure 4**, opportunities discussed to streamline Medicaid LTSS eligibility would typically require Oregon to develop and submit a request to CMS via a Section 1115 demonstration application or amendment. Such processes can be time consuming and require additional state administrative capacity.[18] As described below, there is precedent for a state-funded presumptive eligibility program that operates without a Section 1115 demonstration waiver. This option would still require significant state action and investment to fund such program. Given sufficient time and capacity, there are several steps Oregon could take to expedite the discharge process for individuals who are likely to be eligible for Medicaid LTSS.

→ **Adopting a presumptive eligibility policy** – Presumptive eligibility is a Medicaid policy that authorizes certain qualified entities (e.g., healthcare providers) to screen for Medicaid and CHIP eligibility and enroll individuals who appear to be eligible based on identified criteria. Coverage is immediate and temporary while individuals complete full applications for Medicaid. As a result of the Affordable Care Act, all state Medicaid programs are federally required to implement hospital presumptive eligibility for Medicaid coverage for MAGI groups, which allows hospitals to determine presumptive eligibility. Washington and California are examples of states that have pursued authority to expand presumptive eligibility to LTSS or use presumptive eligibility to cover new groups (beyond MAGI groups) as described below:

Expand Presumptive Eligibility Coverage to New Services

Washington. Under Section 1115 demonstration authority, created a hospital presumptive eligibility program for standard Medicaid benefits and services, as well as for LTSS to identify presumptively eligible beneficiaries for two of its HCBS programs, Medicaid Alternative Care and Tailored Supports for Older Adults.

17 Medicaid eligibility pathways based on old age or disability are known as “non-MAGI” pathways, as they do not use the Modified Adjusted Gross Income (MAGI) financial methodology that applies to other eligibility pathways. Non-MAGI eligibility typically requires demonstration of additional types of need, including limited financial assets or functional needs. Additionally, non-MAGI eligibility requirements vary substantially across states.

18 More detailed considerations and challenges for states when modifying presumptive eligibility or asset testing policy are provided in ATI’s June presentation to the Task Force (link).

Expand Presumptive Eligibility Coverage to New Groups

California. Under Section 1115 demonstration authority, expanded presumptive eligibility 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.

Leverage State Funding for Services under Presumptive Eligibility

Ohio. The Ohio PASSPORT and Assisted Living programs are Medicaid waiver programs that provide services in private residences and residential care facilities. State-funding provides services to PASSPORT and Assisted Living eligible individuals while their Medicaid applications are processed for eligibility, up to 90 days.[lxxv,lxxvi] Ohio operates this presumptive eligibility program without Section 1115 demonstration authority by exclusively funding services during the presumptive period through state dollars. CMS reimburses for services paid by the state-funded program once the person is determined eligible for Medicaid.

→ **Pursuing new Medicaid authorities to streamline the asset test process** – State Medicaid agencies have used asset tests to determine eligibility for Medicaid among non-MAGI populations. In asset testing, an individual's countable assets are considered for Medicaid eligibility. Assets become particularly important in determining coverage for an individual's post-discharge care, such as LTSS. Countable assets 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. Oregon's Medicaid agency uses this 60-month window to review individuals' assets. For individuals in Oregon, the asset limit is $2,000.[lxxvii]

If an individual does not meet the asset limit, the individual must begin spending down assets to become eligible for Medicaid coverage. States are pursuing authority to increase or eliminate the asset limit, shorten the look-back period, or allow self-attestation of application information to streamline and simplify existing processes. 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, with examples included below:[lxxviii,lxxix]

Eliminate Asset Limits

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

Increase Asset Limits

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

Shorten Look-Back Period

New York. Under Section 1115 demonstration authority, increased asset limits to up to $30,182 for an individual applicant, and $40,821 for a couple, which is up from $2,000 per individual applicant and $3,000 per couple. Under Section 1115 demonstration authority, the look-back period for asset verification was shortened from 60 months to 30 months prior to application date for beneficiaries seeking coverage for HCBS.

Decrease Administrative Burden

New Jersey. Under Section 1115 demonstration authority, allowed those with income equal to or below 100% of the federal poverty level, and who need an institutional level of care, to self-attest that assets or resources have not been transferred in lieu of the 60-month look-back period.

Opportunity to Proactively Identify Individuals Who May Qualify for Medicaid HCBS

Outside of Section 1115 Demonstration authority – which can be time and resource-intensive for the state to pursue – Oregon may leverage existing contractual relationships with CCOs / D-SNPs and collaborate with these entities to proactively identify Medicaid HCBS-eligible members in the community prior to hospitalization, which may mitigate downstream delay at the time of hospital discharge. Specifically, Oregon can collaborate with CCOs, D-SNPs, and AAA / APD case managers to advance state goals of identifying members in need of Medicaid HCBS, but are not currently enrolled, and supporting these members in enrolling in and accessing Medicaid HCBS. Additional detail on the state's CCO / D-SNP levers of influence are discussed throughout this report.

ENHANCE CARE MANAGEMENT AND COORDINATION TO FACILITATE CONNECTIONS TO BENEFITS THAT CAN SUPPORT INDIVIDUALS IN THE COMMUNITY

The OHP (Oregon Medicaid) has a strong foundation in care management and coordination through its CCO model. However, interviews revealed that opportunities still exist for Oregon state agencies,[19] providers, and CCOs / D-SNPs to manage and coordinate across settings more proactively and consistently. Additionally, there are opportunities to better connect individuals to the social needs benefits (e.g., nutritious meals, cell phones, or mobile devices to support telehealth access) already available in Oregon through CCOs and D-SNPs. Taken

19 Inclusive of agencies spanning Medicaid, behavioral health, aging, and disability services.

together, strong care management and coordination and connections to social needs benefits can support individuals in being discharged to their homes or community settings, as potential alternatives to institutional placement.

Today, the role of care coordinator is filled by multiple players across the care continuum. Hospitals, primary care providers, CCOs / D-SNPs, other Medicare Advantage plans, and post-acute care providers may have discharge planners, care coordinators, or other clinical and administrative staff engaged when an individual is ready for discharge. AAAs, APD, OHA and Community Mental Health Programs have also played a key role in coordinating care for individuals being discharged from the hospital, particularly those eligible for and receiving ODHS-paid LTSS (i.e., Medicaid-funding nursing facility and 1915(c) services) and OHA-paid 1915(i) services. With so many players filling the role of care coordinator, accountability for care plans and transition support may fall through the cracks.

Enhanced care management is comprehensive care management from a single lead care manager who coordinates all health and health-related care for individuals, including physical, behavioral, and dental care along with social services. Oregon can leverage existing Medicaid managed care and SMAC authority to encourage or require CCOs and D-SNPs to provide enhanced care management for individuals with complex care needs. Through its California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 demonstration, California offers one example of how Oregon can bolster existing contractual expectations for CCOs / D-SNPs to coordinate and manage care for at-risk individuals. Specifically, California leverages its health plan partners to offer the following services for at-risk individuals:[lxxx]

- **Enhanced Care Management:** Health plans offer eligible high-risk members (e.g., unhoused individuals) a single lead care manager. Hospitals must notify health plans or enhanced care managers of a hospitalization within 24 hours. Enhanced care managers are critical in supporting post-acute care, including medication reconciliation and following up on referrals, physical, social, and behavioral health needs.
- **Transitional Care Services:** Health plans offer all members transitional care services to transition between settings, including hospital discharges. The transitional care services care manager will share hospital discharge information with relevant providers, facilitate follow-ups, and refer individuals.

Oregon can bolster its existing care management and coordination requirements and expectations for CCOs / D-SNPs to support more seamless communication between providers and agencies and connect individuals to resources. In particular, the data and information exchange components of California's model could benefit Oregon stakeholders. While Oregon currently facilitates the Collective Platform, which facilitates notifications of ED visits and inpatient admissions, there are opportunities for improvement.[lxxxi] For example, interviews found that primary care providers are sometimes unaware when one of their patients is hospitalized or discharged. Targeted education or requirements for the use of existing platforms could help Oregon providers, CCOs, and others to stay better connected and support patient transitions. With staffing shortages among providers, plans, and agencies continuing to pose challenges, creating clear and efficient processes to transmit information about an individual's status and needs can help reduce staff time spent locating this information or redundancies due to miscommunication.

Definition

Enhanced care management is comprehensive care management from a single lead care manager who coordinates all health and health-related care, including physical, mental, and dental care along with social services.

SPOTLIGHT:

State D-SNP Levers of Influence

State levers to influence care for dual eligible individuals enrolled in D-SNPs have the potential to make an impact on Oregon's challenges (please see a snapshot of Oregon's dual eligible population and D-SNP enrollment in **Key Terms and Coverage Snapshot**). Dual eligible individuals have the longest ALOS in Oregon (4.7 days) as compared to other individuals with other health insurance coverage types (Medicare-only [3.9 days], Medicaid-only [4.0 days], commercially insured individuals [3.0 days]). Oregon has an opportunity to tailor care delivery approaches to address hospital discharge challenges facing the dual eligible population through its SMAC with D-SNPs (please see an overview of the SMAC as a state lever of influence in the **Key Terms and Coverage Snapshot**). There are four key opportunity areas on which Oregon can collaborate with D-SNPs to support the hospital discharge process:

1. **Opportunity Area:** Strengthen D-SNP care delivery model requirements that call for more intensive care coordination supports, especially for services carved out of managed care, during member transitions of care.

   → **In action:** Require D-SNPs to identify and share contact information of a designated D-SNP liaison to communicate and collaborate with ODHS-APD and AAA staff and / or LTSS providers.

2. **Opportunity Area:** Explore opportunities to collaborate with D SNPs around targeted Medicare Advantage supplemental benefits that can support timely and streamlined hospital discharges.

   → **In action:** Require D-SNPs to collaborate with the state to identify and consider prioritizing offering Medicare Advantage supplemental benefits that may best support discharges, including those supporting community living, such as transportation, meals, caregiver supports, as increased social supports.

3. **Opportunity Area:** Enhance existing state reporting requirements to support state oversight of D-SNP performance related to hospital discharges, and transitions of care.

   → **In action:** Require D-SNPs to identify and implement a Quality Improvement Project for a defined population with specific health care needs.

4. **Opportunity Area:** Leverage existing quality improvement efforts and programs to directly address gaps in care and improvements related to supporting transitions.

   → **In action:** Require D-SNPs to report to the state on any D-SNP delegated discharge planning agreements, submission of discharge planning documentation for an annual audit of documentation, and utilization of Medicare Advantage supplemental benefits to support timely and appropriate discharge including transportation, meals, and caregiver supports (please see more information on supplemental benefits in the **Key Terms and Coverage Snapshot**).

INDUSTRY OPPORTUNITIES

As policymakers explore opportunities to mitigate barriers to timely hospital discharge among individuals with complex care needs, physical and behavioral health care providers, hospitals and health systems, and health plans also have a critical role to play in this effort. State action is necessary to facilitate systemic changes across barriers identified in this report. However, industry investments and enhanced collaboration among providers can provide targeted and localized relief to roadblocks to timely discharges discussed in this report. Several opportunities for industry partners are detailed below.

Participate in regional multi-stakeholder care coordination initiatives – Through interviews, stakeholders shared examples of innovative, local partnerships where representatives from hospitals and health systems, local APD or AAAs, and CCOs connect to review cases where individuals are difficult to discharge. As discussed in this report, a regional approach to discharge process improvements is likely to be most effective, given Oregon's existing regional infrastructure across CCOs and AAA / APD.

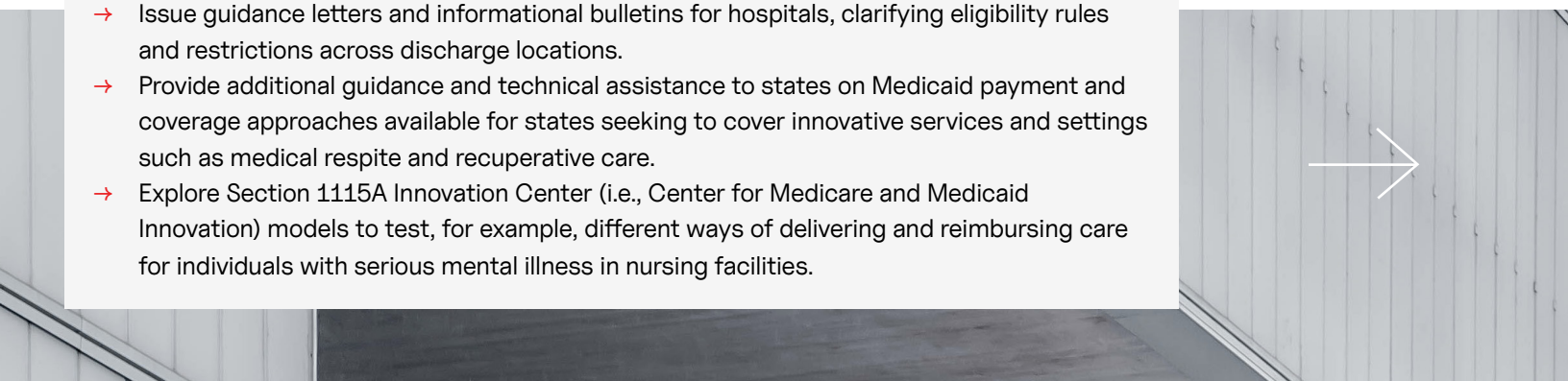
Provide more robust care management services – In addition to connecting individuals to critical health care services, enhanced care management offers opportunities to leverage existing social needs benefits available through OHP and CCOs. Connecting individuals to medical and health-related social services addresses a significant barrier to timely discharge. While the state can support integration between hospital discharge planning, "flexible services," and HRSN benefits, provider organizations can improve these connections by investing in their care management infrastructure (please see "flexible service" and HRSN definitions in the **Key Terms and Coverage Snapshot** section of this report).

Promote access to flexible services – CCOs can currently offer optional health-related "flexible services" to members, which are non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid State Plan. Leveraging existing HRSN and flexible services authorities, CCOs have significant flexibility to offer innovative benefits that meet many of the needs identified by the Task Force, such as housing support, medical respite, and substance use and addiction prevention and recovery. Targeted offerings of the types of benefits most often needed by individuals facing hospital discharge delays and clearly communicating the availability of these benefits to hospitals could support better care transitions.

Federal Opportunity to Support States and Industry Partners in Addressing the Hospital Discharge Crisis

CMS can play a role in supporting states, providers, and health plans in the following ways:

- → Issue guidance letters and informational bulletins for hospitals, clarifying eligibility rules and restrictions across discharge locations.
- → Provide additional guidance and technical assistance to states on Medicaid payment and coverage approaches available for states seeking to cover innovative services and settings such as medical respite and recuperative care.
- → Explore Section 1115A Innovation Center (i.e., Center for Medicare and Medicaid Innovation) models to test, for example, different ways of delivering and reimbursing care for individuals with serious mental illness in nursing facilities.



Focus on reducing hospitalizations – Reducing avoidable hospitalizations is difficult and requires the healthcare system to dedicate resources to access, prevention, and interventions before individuals' needs reach an acute stage. However, it is an important step that payers, hospitals, and other care providers should pursue to alleviate hospital capacity challenges. CCOs can develop reimbursement models that incentivize primary care providers, hospitals, and other providers to prevent unnecessary hospitalizations through increased screening, improved access to primary care, effective care management, and other clinical programs. CCOs and other payers have started to create the right incentives through primary care and hospital VBP models. CCOs can continue to advance these incentives, especially through expanding models that few CCOs have adopted to date such as Patient-Centered Primary Care Homes and total cost of care arrangements.

Create medical respite partnerships – Current reimbursement policy allows for Federally Qualified Health Centers (FQHCs) to operate medical respite care programs as part of their negotiated rate with the state Medicaid program and / or CCOs. FQHCs can partner with a shelter (where FQHC clinical staff enter the shelter setting) or can operate their own recuperative care program (e.g., Central City Concern in Portland). Oregon's Alternative Payment and Advanced Care Model per member per month wrap payments can promote delivery of non-traditional services like respite care. Other medical respite providers can develop strong relationships with State Medicaid agency and CCO staff to establish need for programs and payment rates that cover all services being provided (particularly when providing clinical care and housing). Strong evaluation of outcomes and benchmark goals can help encourage investment and collaboration with CCOs.

Support workforce development – Many workforce programs include provider partners, which are necessary to provide placements for participants to complete training and in some instances seek permanent positions. For example, Oregon's current CNA apprenticeship program includes several SNF partners.[lxxxii] Post-acute care providers can actively seek out these types of partnerships or provide training programs of their own. One SNF organization interviewee had established its own CNA training program, which was successful in supporting CNA recruitment and retention efforts at their facilities.

Conclusion

There are many opportunities for Oregon agencies (inclusive of Medicaid, older adult, behavioral health, and disability services) and their industry partners such as hospitals, providers, CCOs, D-SNPs, and AAAs to promote timely and appropriate hospital discharges for Oregonians with complex care needs. Ultimately, the hospital discharge crisis requires collective effort across systems, state agencies, and providers (inclusive of primary care, behavioral health, social services, acute care, and more) to create a system that enables individuals and their families and caregivers to receive care in the most appropriate setting, in accordance with their needs and preferences. Taken together, opportunities identified in this report provide a roadmap for Oregon to meaningfully improve hospital discharge processes through both the state's existing systems and infrastructure, and by building towards transformative program, policy, and payment approaches.

APPENDIX:

Data Sources and Methods

OVERVIEW OF ATI ADVISORY'S MIXED METHODS ANALYSES

Between January and July 2024, ATI leveraged desktop research, targeted interviews, a survey of providers, and data analysis to determine barriers to timely and appropriate hospital discharge for individuals with complex care needs, along with opportunities. To ensure proposed opportunities were targeted to Oregon's experiences of the hospital discharge crisis, ATI conducted quantitative analyses of various Oregon administrative data sets including the OHA's Healthcare Workforce Reporting Program (HWRP) data set to explore trends in Oregon's post-acute care workforce, and the OHA's All-Payer All Claims (APAC) data set to quantify average hospital length of stay trends.

ATI also designed a survey of Oregon post-acute providers administered in March 2024, and conducted interviews with providers throughout all phases of work. This valuable qualitative input complemented the quantitative insights by providing perspectives on the challenges and practical strategies across a diverse group of stakeholders (please see the **Key Informant Interviews** section for more detail on stakeholder types) to promote timely and appropriate hospital discharges. **Table 1** provides a summary of all mixed methods analyses ATI conducted on behalf of the Task Force, and in close collaboration with LPRO, ODHS and OHA.

Table 1. Summary of ATI's Mixed Methods Approach to Three Core Phases of Analysis

	Key Informant Interviews	Survey	Primary Analysis of Oregon Agency Data
Phase 1: Assessment of provider & workforce capacity *January – April 2024*	Providers and statewide associations, managed care organizations, state and local agencies, and unions	Survey of institutional and home-based providers in Oregon	→ Oregon Health Authority's HWRP Data
Phase 2: Assessment of hospital discharge needs, processes and outcomes *February – May 2024*	Hospitals, state, and local agencies	N / A	→ Wage, retention & turnover among Area Agency on Aging (AAA) and Aging and People with Disabilities (APD) screening & placement staff → Oregon Health Authority's APAC Database
Phase 3: Analysis of benefit coverage / payment rates among commercial & public payers *March – June 2024*	Oregon and external state agencies	N / A	→ Oregon Health Authority's APAC Database

1.1 KEY INFORMANT INTERVIEWS

ATI complemented and validated quantitative analytics with key informant interviews with providers, provider associations, state and county agencies, labor unions, and others across all phases of work. Key informant interviews provided qualitative insights on challenges in ensuring timely and appropriate hospital discharges, along with federal and state policies and regulations that may be contributing to those challenges, and potential solutions. ATI conducted semi-structured interviews with representatives from the organizations listed in **Table 2**. Interviewees were provided questions in advance, with key questions asked across all related interviews, and others tailored more specifically by stakeholder type. ATI took notes in interviews and performed thematic analysis to surface common themes across the interviews, which informed the key findings elevated in this report.

- In the interviews conducted in Phase 1, ATI explored issues related to post-acute care provider capacity and workforce constraints with a particular focus on the specific challenges and potential policy solutions for expediting appropriate placement of individuals with complex needs. ATI, in collaboration with LPRO, selected interviewees to reflect the continuum of post-acute care settings in Oregon's urban, suburban, and rural communities, including post-acute care provider executives, provider association leaders, state and county officials, union representatives, and other key provider types.
- In Phase 2, ATI used interviews to evaluate Medicaid eligibility assessment and placement processes, challenges that may be impeding timely hospital discharge, and regulatory changes or state initiatives or programs that could improve patient flow and enhance coordination among acute and post-acute care providers. ATI also convened a roundtable of state and hospital representatives to discuss the concept of an escalation protocol.
- In Phase 3, ATI interviewed two key groups: (1) key Oregon payers (e.g., aligned CCOs / D-SNPs, ODHS, and OHA) prioritized through Task Force conversations and / or where the state has strong regulatory and payment influence and (2) representatives from other state Medicaid agencies and / or health plans to identify policy and program design opportunities that may be relevant to Oregon. The goal of these interviews was to inform ATI's review of the benefits, coverage, and reimbursement strategies that will be most beneficial to supporting timely and appropriate hospital discharges.

Table 2. Stakeholder Types Represented in ATI's Key Informant Interviews

	Interviewees
Phase 1: Assessment of provider & workforce capacity	→ Associations of primary care, hospital, and post-acute care providers (4) → Coordinated Care Organization (1) → Unions and association of clinical and direct care workers (3) → Post-acute, long-term care, primary care, and dialysis providers (6) → Oregon state and local agencies (2)
Phase 2: Assessment of hospital discharge needs, processes and outcomes	→ Acute care hospitals (2) → Oregon state and local government agencies (3) → Escalation protocol roundtable • Hospitals (2) • Oregon state agencies (3)
Phase 3: Analysis of benefit coverage/ payment rates among commercial & public payers	→ External state Medicaid agencies (2) → Oregon state agencies (2)

1.2 PROVIDER SURVEY

ATI developed and fielded an online survey from February 12, 2024 to March 6, 2024 to 2,136 unique Oregon providers across post-acute and long-term care to better understand provider perceptions of challenges and potential opportunities when serving Oregonians with complex care needs. In total, 364 providers completed ATI's survey. As shown in **Table 3** and **Table 4**, responses represented diversity in provider type and region.[20] Executive directors and administrators of provider types licensed by ODHS and OHA received a link to complete ATI's survey. Respondents were encouraged to consult with staff closest to the organization's overall experience in caring for people with complex care needs when responding.

20 ATI defines Oregon regions consistent with the Oregon Health Authority's COVID-19 Regional Support Approach (link).

Table 3. ATI Provider Survey Response Rate, by Provider Type

Provider Type	Total Providers Reached [1]	Total Responses Collected	% Responses Collected
Nursing Facility	116	26	22%
Residential Care Facility	290	58	20%
Assisted Living Facility	217	41	19%
Adult Foster Home (Aging and People with Disabilities)	1,154	180	16%
Adult Foster Home (Behavioral Health)	75	11	15%
In-Home Care Agency	147	29	20%
Dialysis Center	62	8	13%
Home Health Agency	32	5	16%
Hospice	43	6	14%
Total	**2,136**	**364**	**17%**

Notes: 1 – Indicates the number of unique providers that successfully received a link to ATI's survey via email address.

Table 4. ATI Provider Survey Response Rate, by Region[21]

Region	Total Providers Reached [1]	% Responses Collected
1	1,202	17%
2	293	21%
3	215	20%
5	178	23%
6	23	14%
7	126	19%
9	67	17%
Region Total [2]	**1,991**	**18%**

Notes: 1 – Indicates the number of unique providers that successfully received a link to ATI's survey via their email address. 2 – Not all providers opted to identify the county in which they operated. Accordingly, regional response totals are lower than total response totals.

21 Counties corresponding with each region are provided in the Oregon Health Authority's COVID-19 Regional Support Approach map (link).

ATI's survey included multiple choice, Likert scale, and open-ended questions. ATI analyzed only the completed, most current, unique survey responses by each provider. Any duplicated or incomplete responses were not included in the analysis. For each response, ATI used provider types as a grouping variable to understand how constraints and barriers to complex care delivery vary between different post-acute care provider types. For Likert scale responses, where appropriate, ATI combined responses into one group; for example, responses such as "Strongly Agree" and "Agree" were grouped as a "(Strongly) Agree" response.

LIMITATIONS

Survey data collection is prone to human error, as well as selection and response bias. ATI mitigated these potential biases by:

1. Prioritizing targeted outreach and engagement to non-respondents to maximize participation rates among post-acute care providers. Outreach and engagement included collaborating with ODHS and OHA staff on community outreach via existing social media channels (e.g., Facebook to reach adult foster homes), leveraging OHA / ODHS trusted champions, and weekly follow-up reminders directly from ATI. As shown in **Table 3**, ATI achieved a 17 percent response rate across all provider types surveyed, with a provider-specific response rate of up to 22 percent among nursing facilities;
2. Including "not applicable" or "do not know" response options to all questions to provide respondents with opportunity to opt out of questions; and
3. Seeking review and input from Oregon stakeholders such as state agency staff to ensure that questions were as neutral and clear as possible, and reflective of Oregon's preferred terminology.

1.3 ATI ANALYSIS OF OREGON HEALTHCARE WORKFORCE REPORTING PROGRAM DATA

ATI analyzed post-acute workforce trends in Oregon by analyzing administrative data from the OHA's Health Care Workforce Reporting Program (HWRP). Specifically, ATI leveraged the HWRP data to understand how the workforce of nurses, home health aides, and other post-acute care professionals has changed in Oregon from 2019 through 2022. ATI also used the data to compare the demographics, education levels, and other characteristics between the post-acute care workforce to those employed in the hospital setting. Among the professions that work in the post-acute care field, ATI limited the analysis to groups that had sufficient sample size, as marked by the pink highlight in **Table 5**.

Table 5: HWRP Analysis Sample Sizes by Profession and Setting

Workforce Category	Most Recent Year of Data	Post-Acute	Hospital	Overall[22]
CNA – Certified Nursing Assistant	2022	2,748	2,192	6,271
CNS – Certified Nurse Specialists	2020	1	21	52
CPHT – Certified Pharmacy Technicians	2022	3356	999	5,702
CSWA – Clinical Social Worker Associates	2022	26	49	334
LCSW – Licensed Clinical Social Workers	2022	97	271	2,019
LPC – Licensed Professional Counselors	2022	27	138	3,929
LPN – Licensed Practical Nurses	2022	1,026	124	2,362
NP – Nurse Practitioners	2022	128	232	2,489
OT – Occupational Therapists	2022	361	508	1,964
OTA – Occupational Therapy Assistants	2022	173	35	398
PSY – Psychologists	2022	5	38	1,034
PT – Physical Therapists	2022	684	1,240	4,660
RN – Registered Nurse	2022	2,109	11,639	27,504
RT – Respiratory Therapists	2021	133	1,163	1,724
SLP – Speech Language Pathologists/Pathologists + Audiologists	2021	112	245	2,082
SLPA – SPL Assistants	2021	3	-	227
Grand Total		**7,989**	**18,894**	**62,751**

22 The HWRP includes data representing numerous workforce licensing boards in Oregon, including those beyond the scope of ATI's analysis supporting HB 3396. Accordingly, licensed professionals reflected in ATI's post-acute and hospital setting categories do not represent the overall sample size among professions represented in licensing boards not included in ATI's analysis. Instead, post-acute and hospital categories reflect only those professionals licensed by the Oregon Medical Board, State Board of Nursing, Physical Therapist Licensing Board, Board of Licensed Professional Counselors and Therapists, Board of Psychology, Board of Clinical Social Workers, Board of Examiners for Speech-Language Pathology and Audiology, Board of Pharmacy: Pharmacy Technicians, and the Respiratory Therapist and Polysomnographic Technologist Licensing Board.

Additionally, the analysis was limited to respondents who currently work or intend to work in the state of Oregon to align with the scope of this project. ATI compared the post-acute care workforce to those working in the hospital setting, a major competitor for workforce recruitment. The analysis explored a variety of variables including demographics, average length of employment, region, reported desire to retire or work additional hours, and telehealth utilization.

LIMITATIONS

HWRP public use files are limited to data on licensed professionals in the state of Oregon. Given that surveys are completed at licensure renewal, these data may not be available for all licensees (e.g., those that had not yet renewed a license at the time of the survey). Additionally, the data is not consistent across years and license types (e.g., 2020 data is reported for some license types but not others), which may limit ATI's ability to analyze historical trends and compare these trends between license types. Lastly, as these data are collected through a survey, all data are self-reported and prone to human error.

1.4 ATI ANALYSIS OF OREGON AGING AND PEOPLE WITH DISABILITIES (APD) / TYPE B AREA AGENCY ON AGING (AAA) CASE MANAGER DATA

ATI assessed trends among state and county LTSS placement and assessment staff. Specifically, ATI used case manager employee data from 2019 – 2023 to assess employment, wages, hiring, and tenure among Oregon Department of Human Services – Aging and People with Disabilities (ODHS-APD) and Type B AAA assessment and placement case workers.

The Type B AAA and ODHS-APD case workers conduct LTSS eligibility assessments, conduct LTSS service eligibility/planning/monitoring, and are responsible for diversion transition work or pre-admission screening will be included in the analysis. Sample sizes by role responsibility are described in **Table 6**.

Table 6. Analysis of AAA / APD Case Manager Data, Sample Size

	Provider Category	Maximum Annual Total Full Time Equivalents (FTE) *(Varies Annually)*
ODHS APD	Case Manager 1 – Conducts LTSS financial eligibility assessment	235
	Case Manager 2 – Plans, monitors, and assesses eligibility for LTSS	363
	Case Manager 3 – Conducts diversion transition work and pre-admission screenings	44
Type B AAA	Case Manager 1 – Conducts LTSS financial eligibility assessment	201
	Case Manager 2 – Plans, monitors, and assesses eligibility for LTSS	239
	Case Manager 3 – Conducts diversion transition work and pre-admission screenings	83
Overall Total		**1,165**

LIMITATIONS

ATI cleaned data on employment tenure to ensure that individuals who move positions among case manager categories (as shown in **Table 6** above) were tracked. However, individuals who changed case manager positions may not be reflected in the raw data, which may influence the accuracy of tenure data. Furthermore, there are some gaps in longitudinal data availability for APD case workers, notably missing data for Q3 and Q4 of 2019, 2021, and 2023. Data availability varied by AAA and APD, with **Table 7** displaying the available data by organization. Due to data incompleteness, figures may represent a subset of Oregon AAAs / APD, rather than all of Oregon's case managers.

Table 7. Data Elements included in ATI's Analysis, by AAA / APD

Organization	Total Employed	Employees Leaving	Tenure	Vacancies	Wages
Northwest Senior and Disability Services (NWSDS) AAA	✓	*Voluntary Only*	✓	✓	✓
Multnomah AAA	✓	✓	✓	✓	✓
Oregon Cascades West Council of Governments (OCWCOG) AAA	✓	✓	✓	✓	✓

Organization	Total Employed	Employees Leaving	Tenure	Vacancies	Wages
Lane County AAA	–	–	–	–	*Partial Data*
APD	✓	✓	✓	✓	✓

Note: "–" Denotes unavailable data.

1.5 ATI ANALYSIS OF OREGON ALL-PAYER ALL CLAIMS REPORTING PROGRAM DATA

ATI analyzed Oregon All Payer All Claims data from 2017 to 2022 to understand how the average length of a hospital stay (ALOS) has changed in Oregon by region, payer, discharge destination, hospital type, and complex care diagnostic cohort.

ATI leveraged APAC data, with its International Statistical Classification of Diseases and Related Health Problems-10 (ICD-10) diagnosis codes and procedures codes, to define and quantify six complex care patient diagnostic cohorts: (1) serious mental illness (SMI), (2) substance use disorder (SUD), (3) housing insecurities, (4) Alzheimer's disease and related dementia (ADRD), (5) obesity, and (6) frailty. ATI used a list of ICD-10 diagnosis codes as available in Center for Medicare & Medicaid (CMS) Chronic Condition Warehouse (CCW), in addition to housing insecurity Z-59 codes, to identify complex care diagnoses. For frailty, ATI used the claims-based Kim Frailty Index for individuals older than 65 years old to identify individuals who are moderately or severely frail, as defined by a Kim Frailty index score greater than 0.35.[lxxxiii] To analyze ALOS by hospital type and region, ATI used a list of hospitals with their corresponding region and hospital types from OHA.

ALOS was calculated using geometric means to accommodate extreme outliers, and admissions related to pregnancy and neonatal care were excluded from the analysis.

LIMITATIONS

While the APAC is generally a reliable source of administrative healthcare data among Oregon residents, there are limitations. The APAC data only includes insured residents and does not include any information about uninsured Oregon residents, which represented 4.6 percent of Oregon residents in 2021[23]. The APAC also does not provide data on subgroups of self-insured members.[lxxxiv] Additionally, it is important to note that the APAC represents only adjudicated healthcare administrative claims submitted by providers to Medicaid, Medicare, and Commercial payers. Claims are dependent on professional ICD coding, which means that some diagnoses may be missed or different professional types may have different coding patterns. Accordingly, not all coding may be accurate.

23 The Oregon Office of Health Analytics released a dashboard using Oregon Health Insurance Survey to identify the percentage of uninsured residents (link).

Table 8. List of ICD-10 diagnosis codes for each complex care diagnosis analyzed in the APAC

Serious Mental Illness		Substance Use Disorder			Housing Insecurity	Alzheimer's Disease and Related Dementias	Obesity
F200	F3163	F1010	F13221	F18159	Z59	F0150	E6601
F201	F3164	F10120	F13229	F1817	Z590	F0151	E6609
F202	F3170	F10121	F13230	F18180	Z5900	F0280	E661
F203	F3171	F10129	F13231	F18188	Z5901	F0281	E662
F205	F3172	F10130	F13232	F1819	Z5902	F0390	E668
F2081	F3173	F10131	F13239	F1820	Z591	F0391	E669
F2089	F3174	F10132	F1324	F18220	Z5910	F05	Z6830
F209	F3175	F10139	F13250	F18221	Z5911	G138	Z6831
F21	F3176	F1014	F13251	F18229	Z5912	G3101	Z6832
F22	F3177	F10150	F13259	F1824	Z5919	G3109	Z6833
F23	F3178	F10151	F1326	F18250	Z598	G311	Z6834
F24	F3181	F10159	F1327	F18251	Z5981	G312	Z6835
F250	F3189	F10180	F13280	F18259	Z59811	G3183	Z6836
F251	F319	F10181	F13281	F1827	Z59812	G94	Z6837
F258	F320	F10182	F13282	F18280	Z59819	R4181	Z6838
F259	F321	F10188	F13288	F18288	Z5989	G300	Z6839
F28	F322	F1019	F1329	F1829	Z599	G301	Z6841
F29	F323	F1020	F1390	F1890		G308	Z6842
F310	F324	F10220	F13920	F18920		G309	Z6843
F3110	F325	F10221	F13921	F18921			Z6844
F3111	F3281	F10229	F13929	F18929			Z6845
F3112	F3289	F10230	F13930	F1894			
F3113	F329	F10231	F13931	F18950			
F312	F330	F10232	F13932	F18951			
F3130	F331	F10239	F13939	F18959			
F3131	F332	F1024	F1394	F1897			
F3132	F333	F10250	F13950	F18980			
F314	F3340	F10251	F13951	F18988			
F315	F3341	F10259	F13959	F1899			
F3160	F3342	F1026	F1396	F1910			
F3161	F338	F1027	F1397	F19120			
F3162	F339	F10280	F13980	F19121			
		F10281	F13981	F19122			
		F10282	F13982	F19129			
		F10288	F13988	F19130			
		F1029	F1399	F19131			
		F10920	F1410	F19132			

Serious Mental Illness		Substance Use Disorder			Housing Insecurity	Alzheimer's Disease and Related Dementias	Obesity
		F10921	F14120	F19139			
		F10929	F14121	F1914			
		F10930	F14122	F19150			
		F10931	F14129	F19151			
		F10932	F1413	F19159			
		F10939	F1414	F1916			
		F1094	F14150	F1917			
		F10950	F14151	F19180			
		F10951	F14159	F19181			
		F10959	F14180	F19182			
		F1096	F14181	F19188			
		F1097	F14182	F1919			
		F10980	F14188	F1920			
		F10981	F1419	F19220			
		F10982	F1420	F19221			
		F10988	F14220	F19222			
		F1099	F14221	F19229			
		G621	F14222	F19230			
		I426	F14229	F19231			
		K2920	F1423	F19232			
		K2921	F1424	F19239			
		K700	F14250	F1924			
		K7010	F14251	F19250			
		K7011	F14259	F19251			
		K702	F14280	F19259			
		K7030	F14281	F1926			
		K7031	F14282	F1927			
		K7040	F14288	F19280			
		K7041	F1429	F19281			
		K709	F1490	F19282			
		P043	F14920	F19288			
		Q860	F14921	F1929			
		T510X1A	F14922	F1990			
		T510X2A	F14929	F19920			
		T510X3A	F1493	F19921			
		T510X4A	F1494	F19922			
		Z7141	F14950	F19929			

Serious Mental Illness		Substance Use Disorder			Housing Insecurity	Alzheimer's Disease and Related Dementias	Obesity
		Z7142	F14951	F19930			
		F1110	F14959	F19931			
		F11120	F14980	F19932			
		F11121	F14981	F19939			
		F11122	F14982	F1994			
		F11129	F14988	F19950			
		F1113	F1499	F19951			
		F1114	F1510	F19959			
		F11150	F15120	F1996			
		F11151	F15121	F1997			
		F11159	F15122	F19980			
		F11181	F15129	F19981			
		F11182	F1513	F19982			
		F11188	F1514	F19988			
		F1119	F15150	F1999			
		F1120	F15151	F550			
		F11220	F15159	F551			
		F11221	F15180	F552			
		F11222	F15181	F553			
		F11229	F15182	F554			
		F1123	F15188	F558			
		F1124	F1519	O355XX0			
		F11250	F1520	O355XX1			
		F11251	F15220	O355XX2			
		F11259	F15221	O355XX3			
		F11281	F15222	O355XX4			
		F11282	F15229	O355XX5			
		F11288	F1523	O355XX9			
		F1129	F1524	O99320			
		F1190	F15250	O99321			
		F11920	F15251	O99322			
		F11921	F15259	O99323			
		F11922	F15280	O99324			
		F11929	F15281	O99325			
		F1193	F15282	P0441			
		F1194	F15288	P0449			
		F11950	F1529	P961			

Serious Mental Illness		Substance Use Disorder			Housing Insecurity	Alzheimer's Disease and Related Dementias	Obesity
		F11951	F1590	P962			
		F11959	F15920	T400X1A			
		F11981	F15921	T400X2A			
		F11982	F15922	T400X3A			
		F11988	F15929	T400X4A			
		F1199	F1593	T400X5A			
		F1210	F1594	T400X5S			
		F12120	F15950	T401X1A			
		F12121	F15951	T401X2A			
		F12122	F15959	T401X3A			
		F12129	F15980	T401X4A			
		F1213	F15981	T402X1A			
		F12150	F15982	T402X2A			
		F12151	F15988	T402X3A			
		F12159	F1599	T402X4A			
		F12180	F1610	T403X1A			
		F12188	F16120	T403X2A			
		F1219	F16121	T403X3A			
		F1220	F16122	T403X4A			
		F12220	F16129	T403X5A			
		F12221	F1614	T403X5S			
		F12222	F16150	T40411A			
		F12229	F16151	T40412A			
		F12250	F16159	T40413A			
		F12251	F16180	T40414A			
		F12259	F16183	T40415A			
		F12280	F16188	T40421A			
		F12288	F1619	T40422A			
		F1229	F1620	T40423A			
		F1290	F16220	T40424A			
		F12920	F16221	T40425A			
		F12921	F16229	T40491A			
		F12922	F1624	T40492A			
		F12929	F16250	T40493A			
		F12950	F16251	T40494A			
		F12951	F16259	T40495A			
		F12959	F16280	T404X1A			

Serious Mental Illness	Substance Use Disorder			Housing Insecurity	Alzheimer's Disease and Related Dementias	Obesity
	F12980	F16283	T404X2A			
	F12988	F16288	T404X3A			
	F1299	F1629	T404X4A			
	F1310	F1690	T40601A			
	F13120	F16920	T40602A			
	F13121	F16921	T40603A			
	F13129	F16929	T40604A			
	F13130	F1694	T40691A			
	F13131	F16950	T40692A			
	F13132	F16951	T40693A			
	F13139	F16959	T40694A			
	F1314	F16980	T40711A			
	F13150	F16983	T40721A			
	F13151	F16988	T407X1A			
	F13159	F1699	T408X1A			
	F13180	F1810	T40901A			
	F13181	F18120	T40991A			
	F13182	F18121	Z7141			
	F13188	F18129	Z7142			
	F1319	F1814	Z7151			
	F1320	F18150	Z7152			
	F13220	F18151	Z716			

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