Scaling & Standardizing Specific Needs Contracts and Enhanced Care Services in Oregon

Presented to the Joint Task Force on Hospital Discharge Challenges October 15th, 2024

ATI Advisory

REFRESHER ON TASK FORCE CONVERSATIONS TO-DATE REGARDING SNC AND ECS

November 2023

Phil Bentley (OHCA), Vice Chair Burns, and Lisa Hilty (Sapphire Health Services) presented **provider perspectives in post-acute and long-term care**.

- This included a focused presentation on Specific Needs Contracts (SNC) with Sapphire.

April 2024

At the April meeting, and in its final report to the Task Force, ATI described Oregon's SNCs, Enhanced Care Services (ECS), and Enhanced Care Facilities (ECF).

- Materials included potential **opportunities to leverage existing frameworks to increase provider capacity** to serve individuals with complex needs.

September 2024

The Task Force expressed interest in the ECS/ECF and SNC programs and requested that ATI further investigate what steps might be necessary to **scale and standardize them**, including any fiscal, regulatory, and programmatic changes needed.

TODAY'S AGENDA

- → Overview of SNC and ECS in Oregon
- → Challenges and Opportunities for Scaling and Standardizing SNC & ECS*
  - Regulations, Survey, and Licensing
  - Payments
  - Assessments
- → Moving Forward

*Drawn from Interviews with Agencies, OHCA, and Providers.

Overview of Specific Needs Contracts and the Enhanced Care Services Programs

ADDRESSING COMPLEX NEEDS VIA SPECIALIZED CONTRACT ARRANGEMENTS

Complex Physical and Behavioral Health Needs

- Post-acute care providers in Oregon are experiencing an increase in the complexity of needs of the populations they serve, including complex physical and behavioral health needs and social needs (e.g., lack of stable housing).

Existing Contract and Facility Types with the Potential to Specifically Address a Subset of these Needs:

SNC

- Voluntary program allowing adult foster homes (AFHs), residential care facilities (RCFs), and assisted living facilities (ALFs) to receive a higher payment rate to care for individuals with complex needs that exceed a typical placement.
- Contracts with Oregon Department of Human Services Aging and People with Disabilities (APD), funded via Oregon Health Authority (OHA).

ECS, ECF

- Voluntary program between OHA and APD to support individuals with complex medical and psychiatric needs.
- Provided within ECFs in 6 Oregon counties (specific RCFs and select units of Nursing Facilities [NF]).
- Includes intensive mental health services and wrap-around supports with additional staff and enhanced payment rates.

Sources: Opportunities for Oregon to Promote Timely and Appropriate Hospital Discharge. ATI Advisory, August 2024. HB 3396. Oregon Legislative Assembly, June 2023. OAR 411-027: Payment Limitations in HBCS. ODHS, 2023. Specific Needs Contracts. ODHS. Enhanced Care Services Information Sheet. OHA, June 2024. OAR 309-019-0155: ECS and ECOS. OHA.

BOTH PROGRAMS PROVIDE ENHANCED RATES FOR COMPLEX NEEDS IN SELECT FACILITY AND COMMUNITY-BASED SETTINGS; ELIGIBILITY AND STAFFING REQUIREMENTS VARY

Specific Needs Contracts

Settings:

- Specific contracted beds within AHFs, RCFs, and ALFs

Resident Eligibility (must meet all the listed criteria):

- Currently in a NF or being diverted from NF placement
- Eligible for Medicaid Long-Term Care Services
- Has activities of daily living (ADL), medical, or behavioral needs requiring 24/7 support
- Belongs to one or more of the following target groups: Bariatric, Complex Medical, Challenging Behaviors, Dementia, HIV/AIDS, Hospice, Traumatic Brain Injury, Ventilator

Staffing:

- In addition to general AFH/RCF/ALF staffing requirements, each SNC specifies staffing requirements for each contracted facility/target group, such as additional behavioral or rehabilitative staff, activity coordinator, etc.

Enhanced Care Services

Settings:

- ECFs (specific APD-licensed RCF or units of select NF) with on-site mental health supports 4+ hours daily

Resident Eligibility (must meet all the listed criteria):

- Eligible for services through APD and requires rehabilitative mental health treatment
- History of APD placements due to complex behaviors
- Currently or has been a patient of Oregon State Hospital or received inpatient psychiatric care for >14 days
- Meets diagnosis of Serious Mental Illness and exhibits behaviors requiring a high level of treatment (self-endangering, aggression, psychiatric medication needs, etc.)

Staffing:

- In addition to general RCF/NF staffing requirements, must have onsite Qualified Mental Health Professional (QMHP) and access to psychiatric consultation (psychiatrist on staff for ECFs with 10+ patients)

Sources: OAR 411-027: Payment Limitations in HBCS. ODHS, 2023. Specific Needs Contracts. ODHS. Enhanced Care Services Information Sheet. OHA, June 2024. OAR 309-019-0155: ECS and ECOS. OHA.

SNC AND ECS PAYMENT TERMS ARE FACILITY-BASED AND DIFFER ACROSS THE PROGRAMS

- SNC and ECS payment rates are established at the facility level, with each facility receiving an established rate per individual served under these contract arrangements.

- SNC rates vary based on facility and the target group served within each facility (e.g., Bariatric, Dementia, Ventilator), while ECS rates vary based on facility type (e.g., RCF vs. units of select NF).
  - Rates for AFH SNCs and ECS are established per the APD rate schedule, while rates for ALF/RCF SNCs are established individually for each participating facility.

- Payment methodology for behavioral health services differs between SNC and ECS arrangements, with behavioral health services paid for on a per-service basis for SNC, and on a per diem basis (bundled payment) for ECS.

- *Additional detail on payment rates and methodology for SNC and ECS is provided in the Appendix.*

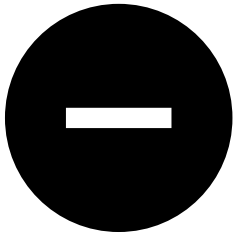
SNC & ECS MAY PROVIDE AN OPPORTUNITY TO CARE FOR MORE INDIVIDUALS WITH COMPLEX CARE NEEDS, BUT THERE ARE BARRIERS TO OPTIMAL IMPLEMENTATION

Improving SNC and ECS could encourage greater participation in the programs, enabling more post-acute placement settings for individuals with complex care and social needs.

To be successful, program improvements must be accompanied by solutions that address underlying workforce challenges and payment disparities across services and settings.

*Improving and/or scaling SNC & ECS **may enable**:*

- Access to specific contracts and placements that can more adequately address complex physical and behavioral health needs than typical post-acute care settings
- Collaboration between agencies and facilities to appropriately support patients and providers
- Proactive, accurate assessments of patient needs for appropriate placements



*Improving and/or scaling SNC & ECS **does not address:***

- Workforce shortages and lack of behavioral health provider capacity to fully staff contracts/facilities
- Shortage of public guardians
- Staff shortages in agencies for adequately forecasting caseloads and providing training/technical assistance to support providers

Challenges and Opportunities for SNC and ECS Programs

(Drawn from interviews with representatives from OHA, APD, OHCA, and providers with SNC & ECS arrangements in AFHs, RCFs, and NFs)

STAKEHOLDERS HIGHLIGHTED KEY CHALLENGES WITH PARTICIPATION IN THE SNC AND ECS PROGRAMS

→ Providers* and agencies interviewed by ATI identified challenges with participation in the SNC and ESC programs. These areas are:

1. Surveys and licensing requirements
2. Payment adequacy and methodology
3. Assessment tools, processes, and communication

→ Interviews informed ATI's key takeaways related to policy, regulatory, and programmatic opportunities for the Task Force to consider as it proceeds with recommendations to the legislature.

*Providers eligible for or with SNC and/or ECS arrangements. ATI interviewed AFHs, RCFs, and NFs.

SURVEYS AND LICENSING REQUIREMENTS LEAD TO INAPPROPRIATE PLACEMENTS AND CREATE BARRIERS TO NEW PROVIDER ENTRANTS *(1 of 2)*

	Key Themes from Interviews with OHA, APD, OHCA, and Providers	Interviewee-Identified Opportunities
1 Behavioral Health (BH) APD Exclusion	▪ Individuals whose primary diagnosis is a **BH need cannot be placed in APD-licensed settings**. ▪ Due to limited BH capacity in OHA, individuals with **significant co-occurring BH needs often end up in APD SNC settings** not equipped to address these needs (and unable to pay for or manage BH services).	▪ **Remove APD exclusion** for individuals who have a mental health-related primary diagnosis to support shared APD/OHA regulatory and licensing framework. ▪ Create **waiver and regulatory flexibility** to pay for psychiatry, rehabilitation, and BH supports under SNC and in LTSS. ▪ Statutory and funding **authority** from legislature **to develop rehab services under APD**.
2 Barriers to Providers Entering the Market	▪ Providers report licensing requirements are expensive, burdensome, and time-consuming, creating **barriers for new providers to enter the market**. *Data Note: The number of licensed AFHs in OR has decreased by almost 20% since 2016. AFH owners are shifting to other client/setting types and are exiting the market altogether, and fewer AFH providers are entering the market.*	▪ **Streamline and update licensure processes** to allow for additional facilities and placements. ▪ **Analyze other states' provider licensing requirements** to identify opportunities for enabling new providers to enter the market.

Efforts to remove the exclusion of APD serving individuals whose primary driver of need is a behavioral health concern are underway as part of the agencies' multi-year Joint-agency Policy Option Package, as presented at the September 2024 Task Force meeting.

Source: 2021 Adult Foster Home Resident and Community Characteristics Report on Adult Foster Homes. Portland State University Institute on Aging, 2021. 42 CFR 483.106(e). Code of Federal Regulations. Current and ongoing cross-agency work regarding 1915 services and screening processes. ODHS and OHA, 2024.

SURVEYS AND LICENSING REQUIREMENTS LEAD TO INAPPROPRIATE PLACEMENTS AND CREATE BARRIERS TO NEW PROVIDER ENTRANTS *(2 of 2)*

"In Oregon, you have to wait two years to open and fill a new ventilator home. There is only one ventilator home in Oregon with a waiting list for additional placements [under SNC]. During the first year, you can only have one resident, and it takes two years to get to full capacity. In Washington, there is no two-year rule. I can go across the border and open a new home with six residents in the first year as a new provider."

- AFH Ventilator-Assisted Care Provider

SNC AND ECS PAYMENT RATES AND METHODOLOGY LIMIT PROVIDERS' ABILITY TO COMPETE FOR STAFF AND APPROPRIATELY STAFF CONTRACT ARRANGEMENTS *(1 of 3)*

	Key Themes from Interviews with OHA, APD, OHCA, and Providers	Interviewee-Identified Opportunities
1 Behavioral Health Services Payments	▪ SNC providers reported that **moving BH services from per diem to per service payments** has impacted their ability to maintain BH staff. ▪ Rates for BH providers have increased over recent years but are **not keeping pace with cost-of-living growth**. ▪ QMHP are generally employed by local mental health departments, and providers under SNC & ECS arrangements **cannot directly hire or staff QMHPs in their facilities**.	▪ Legislative support to **increase rates for BH providers**, with **prescriptive direction** on providers needing rate increases. ▪ **Conduct a rate study and case load forecast** to assess supports for providers serving populations with complex needs (or in rural areas, smaller facilities). ▪ Regulatory flexibility to **allow SNC providers to directly hire QMHPs**.
2 Payment Parity Across Settings/ Agencies	▪ BH services are paid for under OHA, **limiting APD's ability to influence payments and QMHPs' participation** in SNC & ECS arrangements. ▪ **Payment disparities across settings and agencies** limit providers' willingness to participate in SNC & ECS arrangements. Agencies and settings with greater payments and licensing flexibility can more easily attract providers.	▪ **Work towards payment parity** across settings and agencies to help SNC & ECS providers hire necessary staff.

SNC AND ECS PAYMENT RATES AND METHODOLOGY LIMIT PROVIDERS' ABILITY TO COMPETE FOR STAFF AND APPROPRIATELY STAFF CONTRACT ARRANGEMENTS *(2 of 3)*

	Key Themes from Interviews with OHA, APD, OHCA, and Providers	Interviewee-Identified Opportunities
3 SNC Rates	▪ SNC rates are reported to be **insufficient to staff the amount and types of providers needed** to adequately address complex needs. ▪ Rates are not sufficient to **pay competitive, sustainable wages**. ▪ Providers in smaller settings (AFHs) report receiving **lower rates than larger facilities while maintaining greater staffing ratios**.	• **Increase SNC rates** to allow for competitive staff wages and sustainable, adequate staffing. • **Conduct a study** to determine appropriate rates and associated staffing ratios across facility types.
4 Maintaining Capacity	▪ Providers across settings report a key challenge for keeping appropriate staffing and preventing burnout is having an **unpredictable census or operating below full census.** Operating below census also occurs when providers are required to **hold beds for individuals temporarily absent** from the facility. ▪ Capacity challenges may also encourage providers to take on **patients they are not well-equipped to serve**.	• **Streamline contracting and placement processes** to support facilities maintaining capacity. • **Assess bed hold policy** to support providers not at capacity due to temporary facility absences.

Sources: ODHS APD OAR Chapter 411 Division 085: Nursing Facilities/Licensing. ODHS APD, 2024.

SNC AND ECS PAYMENT RATES AND METHODOLOGY LIMIT PROVIDERS' ABILITY TO COMPETE FOR STAFF AND APPROPRIATELY STAFF CONTRACT ARRANGEMENTS *(3 of 3)*

"I have to work two days to get one day off. […] When I lost two clients, I still had to maintain the full staffing required under my [SNC]. It takes months to recover when I am not at full capacity."

- AFH Provider

ASSESSMENT TOOLS AND PROCESSES ARE NOT CURRENTLY CAPTURING OR COMMUNICATING THE FULL SCOPE OF INDIVIDUALS' NEEDS *(1 of 2)*

	Key Themes from Interviews with OHA, APD, OHCA, and Providers	Interviewee-Identified Opportunities
1 Assessment Tool	▪ Current **assessment tools may be out of date** and not adequately capturing patient needs for appropriate placements and payment rates (e.g., not capturing full ADL/IADL needs or full extent or severity of complex BH needs). ▪ Different assessment tools and processes across agencies creates **duplication and discrepancies in assessment processes**, impacting ability to appropriately place individuals with complex needs.	▪ **Consider newer**, nationally **standardized assessment tools.** ▪ **Align assessment tools across agencies** to allow a joint assessment to better identify and place individuals with complex needs.
2 Assessment Accuracy	▪ **Pressures to quickly discharge and place patients** may lead to **underrepresentation of patient needs** or limited communication on patient complexity. Inappropriate placements due to inadequate needs assessments creates churn between the Emergency Department, hospitals, and post-acute care settings.	▪ **Train discharge planners and case managers** to better understand why this information is important for providers. ▪ **Support providers** following discharge to appropriately address complex BH needs.

Efforts to implement new assessment tools for level of care determination are underway as part of the agencies' multi-year Joint-agency Policy Option Package, as presented at the September 2024 Task Force meeting.

Source: Rate Schedule – Effective July 1, 2024. DHS, 2024. Current and ongoing cross-agency work regarding 1915 services and screening processes. ODHS and OHA, 2024.

ASSESSMENT TOOLS AND PROCESSES ARE NOT CURRENTLY CAPTURING OR COMMUNICATING THE FULL SCOPE OF INDIVIDUALS' NEEDS *(2 of 2)*

"There is huge variety in the quality of the assessments. Case managers need to look beyond what consumers *say*, as many older adults may underrepresent their needs or challenges."

- Agency Staff

Moving Forward

POTENTIAL AGENCY AND LEGISLATIVE OPPORTUNITIES TO SUPPORT SNC & ECS ARRANGEMENTS IN OREGON

Agency (OHA and APD) Opportunities

Near-term (2025) with additional funding/resources

- **Training and Technical Assistance:**
  - Provide training to case managers and discharge planners to enable better assessment processes.
  - Support post-acute care providers to better address complex/challenging behaviors in SNC and ECS arrangements, such as through additional training or dedicated care teams.
  - Review alternatives to current penalties for noncompliance with licensing requirements, such as technical assistance or agency guidance.
- **Assessment Tools and Processes:**
  - Explore potential updates to current assessment tool.*
  - Work with providers across hospital and post-acute care settings to better align assessment tool processes.
- **Rate Studies, Analysis, and Forecasting:**
  - Analyze state licensing requirements for providers in SNC and ECS to identify opportunities for streamlining.
  - Conduct a rate study for BH providers under SNC and ECS arrangements to assess payment rate adequacy.

Legislative Opportunities

Near-term (2025) and intermediate-term (2026)

- **Funding (near-term 2025):**
  - Invest in agency staff for OHA and APD to accommodate additional provider engagement and training, analysis of or revisions to rates and regulations, and caseload forecasting.
- **Rates and Rate Methodology (intermediate-term 2026):**
  - Support rate increases for BH providers, with guidance on provider types and contracts needing increases.
  - Enable rate increases for SNC to allow for competitive staff wages, and work towards payment parity.
- **Statutory Authority to Enable Agency Collaboration on BH Services (intermediate-term, 2026):**
  - Explore allowing APD-licensed providers to employ QMHPs.
  - Provide statutory and funding authority to develop rehabilitative, psychiatry, and BH supports under SNC.
  - Remove APD exclusion to support shared APD/OHA regulatory and licensing framework.*

* Efforts underway as part of agencies' multi-year Joint-agency Policy Option Package, as presented at the September 2024 Task Force meeting.
BH – Behavioral Health

Appendix

DISTINGUISHING FEATURES OF SNC & ECS – PAYMENTS

SNC and ECS payment rates are established at the facility level, with each facility receiving an established rate per individual served under these contract arrangements. SNC rates vary based on the target group served within each facility, while ECS rates vary based on facility type. Payment methodology for BH services differs between SNC and ECS arrangements.

Key areas of confusion → Payment rates, rate differences across target groups and facility types, general payment methodology, payment methodology for BH services.

Specific Needs Contracts Payments

- Specific Needs Contracts are paid at a set rate per person within a given facility.
- Rates set at the facility level – the same rate is paid for each person within a given provider facility, regardless of individual acuity or needs.
- BH/Mental Health services not included in rates and are paid for by service through Enhanced Care Outreach Services (ECOS) or BH ancillary services.
- **AFH SNCs:** Rates established by target group and apply across all AFHs.
- **RCF and ALF SNCs:** Rates established individually for each facility. Facilities are paid an established rate for each individual they serve, up to a set payment ceiling, and up to a specified number of contracted beds. Rates are determined based on the target group served by each facility.

Enhanced Care Services Payments

- Uses bundled rate code for residential programs rather than billing by service. Bundled rate includes BH services and all other necessary services.
- BH services paid per diem.
- Rates increased during initial COVID-19 pandemic for ~6-9 months; rates have since decreased but still above pre-pandemic rates.
- BH services received net 30% increase under HB522 in 2021 (across all services) – higher proportion went to residential services than outpatient.
- **ECFs:** Enhanced Care Facilities receive a set rate per the APD rate schedule per individual served under this contract arrangement. Per person rates are higher for those in units of select NFs than those in RCFs.
- **NF Rate:** $21,335 per individual served.
- **RCF Rate:** $17,678 per individual served.

Sources: Rate Schedule – Effective July 1, 2024. DHS, 2024. Specific Needs Contracts. ODHS.