Recommendations of the Joint Task Force on Hospital Discharge Challenges

Letter from Chair and Vice Chair

To the Oregon Legislative Assembly:

In 2023, Oregon legislators established the Joint Task Force on Hospital Discharge Challenges to address the needs of Oregonians who are waiting in hospitals to be discharged to the next appropriate level of care. These individuals must navigate a complicated path of eligibility determinations, clinical screenings, referral processes and coverage programs, as they seek to transition to community, long-term or post-acute care. Oregonians face these discharge challenges at vulnerable moments in their lives, often following an acute illness or injury necessitating a hospital stay. Many of these individuals face additional challenges such as chronic health conditions, limited social support, housing insecurity, or homelessness.

As providers who serve these individuals in our daily work, we have been honored to serve as the Chair and Vice Chair of this Task Force and would like to thank our fellow members for their dedication and creativity as we sought multi-sector solutions to these complex problems. Members have devoted substantial time and effort over the past year and a half to studying factors contributing to discharge challenges, bringing insights from their own sectors and a willingness to learn from others in the group as we mapped the complex processes and systems at the heart of this issue. We have documented our findings and recommendations in this report.

We thank the Legislative Assembly for providing an opportunity for us to advance these recommendations and respectfully urge your action on these strategies in the upcoming 2025 session. As you consider the recommendations herein, we hope you will call upon this group to answer any questions and continue the conversation about legislative next steps.

Respectfully submitted,

Jimmy Jones	Elizabeth Burns
Chair	Vice-Chair

Task Force Members

Jimmy Jones, Chair
Elizabeth Burns, Vice-Chair

Phil Bentley
Rachel Currans Henry
Daniel Davis
Jeff Davis
Jonathan Eames
Eve Gray
Felisa Hagins
Jesse Kennedy

Sen. Deb Patterson
Rep. Christine Goodwin

Kathleen LeVee
Alice Miller
Leah Mitchell
Raymond Moreno
Joe Ness
Nikki Olson
Sarah Ray
Jane-Ellen Weidanz
Jonathan Weedman

Acknowledgements

This report draws extensively from analysis conducted by ATI Advisory. LPRO thanks agency partners for information and analysis responsive to Task Force requests: Regan Sheeley of the Oregon Department of Human Services, and Katie Mayward and Brian Stafki of the Oregon Health Authority, along with many others who contributed their time and effort to the work of the Task Force. Finally, The Task Force acknowledges the contributions of members who completed their service to the Task Force prior to this report: Trilby de Jung and Dawn Wipf.

Staff

Shauna Petchel, Research Analyst | shauna.petchel@oregonlegislature.gov

Daniel Dietz, Legislative Analyst | daniel.dietz@oregonlegislature.gov

Timothy Merrill, Committee Assistant | timothy.merrill@oregonlegislature.gov

Oregon State Legislature

Oregon State Capitol | (503) 986-1813 | www.oregonlegislature.gov

Executive Summary

Recommendations of the Joint Task Force on Hospital Discharge Challenges

DECEMBER 2024

In 2023, Oregon lawmakers confronted the problem that people were becoming stuck in hospitals when they were unable to be discharged to an appropriate post-acute care setting. This issue, while not new, was greatly exacerbated during the COVID-19 pandemic when the post-acute care sector faced severe disruptions. These challenges persist now as hospitals serve an aging population with growing needs for mental health, addiction, and housing supports that the traditional post-acute care model was not designed to address. As a result, Oregon's limited hospital beds are often in use to care for people who are ready to be discharged to less intensive care settings.

The Legislative Assembly established the Joint Task Force on Hospital Discharge Challenges through House Bill 3396 (2023) to study these issues and recommend changes. The recommendations in this report result from more than a year of deliberations by the 22 members of the Task Force. This work involved a detailed examination of why patients face challenges discharging from the hospital. Members considered hospital and state agency processes, as well as structural factors constraining the capacity of the post-acute sector. At each step, the Task Force heard from a range of stakeholders, identified areas of common ground, and aimed to center the needs of individuals who cannot access the care they need.

As this report reveals, no single factor drives Oregon's hospital discharge challenges. The care continuum is challenged at multiple points: within hospitals and community-based settings, at the agencies responsible for determining eligibility for long-term care, and further upstream in the education and career development settings that train the post-acute workforce. Addressing any of these challenges in isolation is unlikely to achieve the goals of HB 3396.

With awareness of these interconnected challenges, the Task Force advanced recommendations as a series of linked strategies rather than a list of individual concepts. Some strategies emphasize near-term actions the Legislative Assembly could take in the 2025 session. Others are multi-year efforts requiring continued engagement from the stakeholders who developed these recommendations.

The full list of recommendations is summarized below.

Recommendations

The Task Force recommends the State of Oregon take the following actions:

1. **Update eligibility processes and workflows for long-term services and supports (LTSS).** Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) should be directed to streamline processes for screening and eligibility determinations for Medicaid LTSS, which is the primary payer for long-term care. For people who are likely to be determined eligible, Medicaid LTSS coverage could begin immediately while agencies complete the full determination process.
2. **Waive or streamline asset testing for LTSS.** Verification of financial assets contributes to delays for people eligible for LTSS and poses a hardship for people with cognitive impairment or limited social supports.
3. **Increase support for legal guardians.** Increased capacity at the Office of the Public Guardian and community-based organizations would address delays for people who lack capacity to make care decisions.
4. **Refine the regulatory framework to support complex care.** The agencies should study regulations and processes to address provider concerns about risks of accepting high-acuity clients with complex needs. Existing programs could also be expanded to provide specialized post-acute care.
5. **Expand medical respite (MR) statewide.** MR programs should be expanded through Coordinated Care Organizations to offer recuperative care for Oregon Health Plan (OHP) members who are homeless when they discharge from the hospital.
6. **Coordinated Care Organizations and Dual-Eligible Special Needs Plans.** OHA should use its existing managed care authority to promote coverage of social needs and home modification supports and require enhanced coordination for people discharging from hospitals.
7. **Update reimbursement methods for Adult Foster Homes.** Increased rates should provide greater transparency and parity for these providers.
8. **Extend the Post Hospital Extended Care benefit.** OHP should cover up to 100 days of skilled nursing to address coverage gaps.
9. **Leverage existing initiatives to develop the post-acute workforce pipeline.** Strategies should address career pathways and background checks for post-acute workers. Changes in nurse faculty pay and nursing student clinical placements would increase the nursing workforce pipeline.

This report is available online at [URL to be inserted in adopted report].

Table of Contents

Acronyms Used in This Report

AAA — Area Agency on Aging
ACA — Affordable Care Act
ADL — Activities of daily living
ADRD — Alzheimer's or dementia-related diseases
AFH — Adult foster homes
ALF — Assisted living facilities
ALOS — Average length of stay
APD — Office of Aging and People with Disabilities
ARPA — American Rescue Plan Act
BCU — Background Check Unit
CBC — Community-based care facility
CCO — Coordinated care organization
CHIP — Children's Health Insurance Program
CMS — Centers for Medicare and Medicaid Services
CNA — Certified nurse assistant
COGAP — Central Oregon Guardian Assistance Program
CSRA — Community spouse resource allowance
D-SNP — Dual-Eligible Special Needs Plan
ECF — Enhanced Care Facilities
ECS — Enhanced Care Services
FRO — Future Ready Oregon
HCBS — Home and community-based services
HHA — Home health agency
HRS — Health-related services
HRSN — Health-related social needs
IDD — Intellectual and developmental disabilities
ILOS — In lieu of services
LPN — Licensed practical nurse
LTSS — Long-term services and supports
MHACBO — Mental Health & Addiction Certification Board of Oregon
ODDS — Office of Developmental Disability Services
ODHS — Oregon Department of Human Services
OHA — Oregon Health Authority
OHCS — Oregon Housing & Community Services
OHP — Oregon Health Plan

OPG — Oregon Public Guardian & Conservator
OSP — Oregon State Police
NF — Nursing facilities
PHEC — Post-hospital extended care benefit
PE — Presumptive eligibility
QE — Qualified entities
RCF — Residential care facilities
SDM — Supported decision-making
SMAC — State Medicaid Agency Contract
SMI — Serious mental illness
SNAP — Supplemental Nutrition Assistance Program
SNC — Specific Needs Contract
SNF — Skilled nursing facility
SOQ — Safety, Oversight and Quality
SSI — Supplemental Security Income

Introduction

When the COVID-19 public health emergency ended in May of 2023, Oregon policymakers confronted a set of challenges both familiar and new. Since before the pandemic, people with complex medical and behavioral health needs have faced significant challenges when they leave the hospital. Among Oregonians discharged from a hospital stay, more than half (58%) have a diagnosis that requires ongoing complex care or specialized supports, such as such as serious mental illness, Alzheimer's or related dementias, frailty, or substance use disorder.[1] When this care is not readily available, patients can become stuck in the hospital after acute care is no longer needed. Oregon has the second lowest number of hospital beds per capita (1.6 per 1,000) among all states, and delays in discharge also create access challenges for others needing a hospital bed.

Exhibit 1. Housing Insecurity and Hospital Discharge Challenges

People with housing insecurity:

- have the most emergency department visits (4.8, compared to 1.7 for all patients)
- have the second highest length of stay of any complex care cohort (5.4 days, compared to 3.9 for all patients)
- are most likely to be discharged to "home" or self-care (73%, compared to 63% of all patients)

Source: ATI Advisory (May 2024) at https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283993

The surge in patients needing hospital and post-acute care during the pandemic exacerbated these challenges, overwhelming hospitals, caseworkers, and long-term care workers. Immediate solutions to "decompress" hospitals had mixed results.[2] These challenges persist in the aftermath of the pandemic as the health care system experiences historic levels of worker turnover and burnout coinciding with the arrival of the "silver tsunami" – substantial growth in Oregon's older adult population. Over time, Oregon has seen an increasing number of people waiting in hospital beds without the right mix of coverage, incentives,

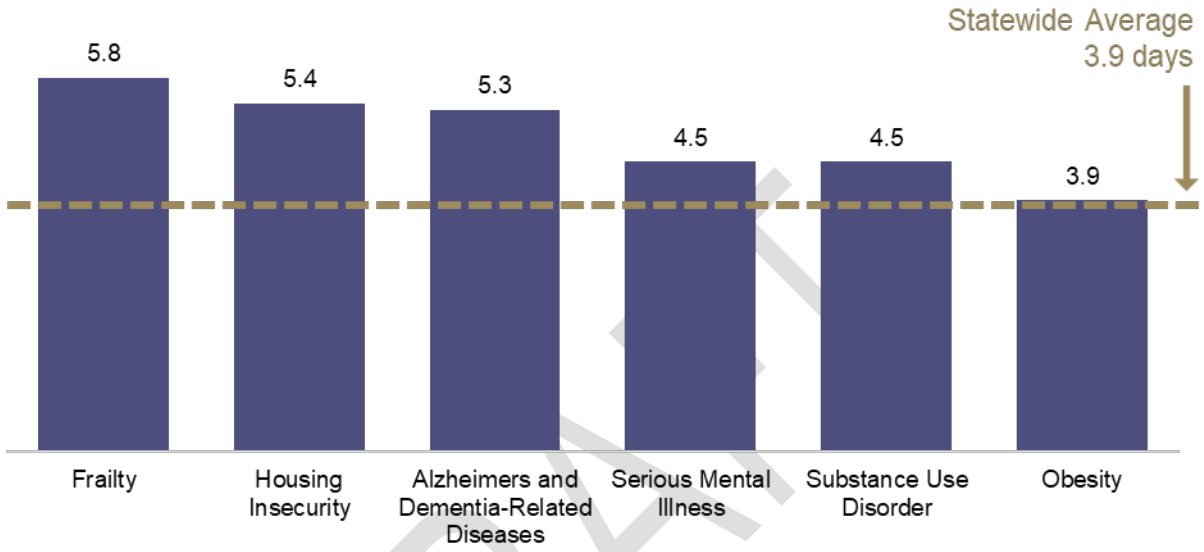
[1] ATI Advisory. "Assessing Oregon's Hospital Discharge Processes and Experiences – Challenges and Opportunities," at 10. May 23, 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283993

[2] Weidanz, J.E. "House Bill 3396 Task Force," September 21, 2023, at 29-32. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/277455

community-based care facilities, or workforce to get people to the appropriate setting. [3]

The most vulnerable Oregonians wait the longest to discharge. Between 2017 and 2022, hospital lengths of stay ranged from 3.9 to 5.8 days for people with certain complex care diagnoses, compared to the state average of 3.9 days.[4] People stay longer when they lack stable housing or social supports (see Exhibit 2).

Exhibit 2. Average Length of Stay (days), by Diagnosis (2017-2022)



Source: Adapted from ATI Advisory. "Assessing Oregon's Hospital Discharge Processes and Experiences – Challenges and Opportunities," at 10. May 23, 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283993

People experiencing homelessness are also more likely to be discharged to "home or self-care," even with complex care needs.[5] They are significantly more likely to return to the emergency room.[6]

[3] ATI Advisory, *supra* note 1, at 12. Oregon hospitals saw average length of stay (ALOS) increased by 27% among all insured Oregonians between 2017-2022.[3] Total patient days in the hospital in Oregon increased by 20% across all hospital regions, across all insurance coverage types, and among all hospital types.[3] Hospital reimbursement typically does not fully account for longer stays.

[4] *Id.*

[5] *Id* at 13.

[6] *Id* at 5.

[date of finalization]

As this report details, there are multiple issues driving Oregon's challenges helping people transition from hospital to community-based care.

- **Process barriers can prevent people from accessing insurance coverage and care coordination** needed to ensure timely discharge to post-acute care.[7] The screening process for Medicaid long-term services and supports (LTSS) is time-intensive and challenged by administrative siloes in coverage for physical and mental health needs. As the work has become more complex and wages have fallen behind inflation, more experienced caseworkers are leaving the field.[8] Eligibility caseworkers and hospitals struggle to communicate and coordinate during the discharge process.
- **Long term care providers struggle to meet the complex care needs of many clients,** posing safety risks for patients and workers and compliance risks for facilities. Nursing facilities may be unwilling to accept patients with complex needs, uncertain Medicaid coverage, or nowhere to discharge following a nursing facility stay. Adult foster homes, which may be more willing to accept individuals with complex needs, report being unable to retain staff under the state's existing payment approach. For both adult foster homes and larger facilities, license types, survey burden, and uncertainty in reimbursement levels contribute to providers declining individuals with complex care needs even when they otherwise have capacity.
- **Workforce shortages exacerbate process challenges at every point on the care continuum,** from hospitals to agency caseworkers to long term care settings. Hospitals and long-term care facilities depend on a workforce pipeline that produces far fewer nurses than the state needs. Direct care workers and Certified Nurse Assistants (CNAs), who are critical to caring for people with complex needs, experience long waits for background check clearances and have few opportunities to advance in their careers.

This multi-faceted problem also represents an opportunity for Oregon. Since neither the problem nor potential solutions belong to any single sector, partners from across Oregon's health care and long-term care systems could craft solutions collaboratively. Doing so requires earnest inquiry and willingness among partners to adopt a system-wide perspective and learn more about each other's challenges. Ultimately, collaborative problem-solving may better prepare Oregon to serve its

[7] *Id.*

[8] *Id* at 16.

aging population, many of whom will face social isolation and housing insecurity[9] in the years ahead.

Headwinds against potential solutions include the end of federal pandemic relief funding, an uncertain economic outlook in the state, and workforce issues that span the public and private sectors. The Task Force faced the challenge of developing solutions that are actionable and precise even as they address the multifaceted problem.

Policy Framework and Deliberative Process

In recognition of these challenges, the Legislative Assembly approved House Bill 3396 in the 2023 legislative session. The measure established the Joint Task Force on Hospital Discharge Challenges, charging the group with studying root causes and developing recommendations to address the challenges people face in discharging from hospitals to post-acute care. The measure took effect July 27, 2023, upon signature of Governor Tina Kotek, with members appointed shortly after. The Task Force was directed to deliver its recommendations to the Legislative Assembly by November 15, 2024.

Four Policy Domains

HB 3396 provides a policy framework to guide the Task Force's analysis and recommendations, allowing for

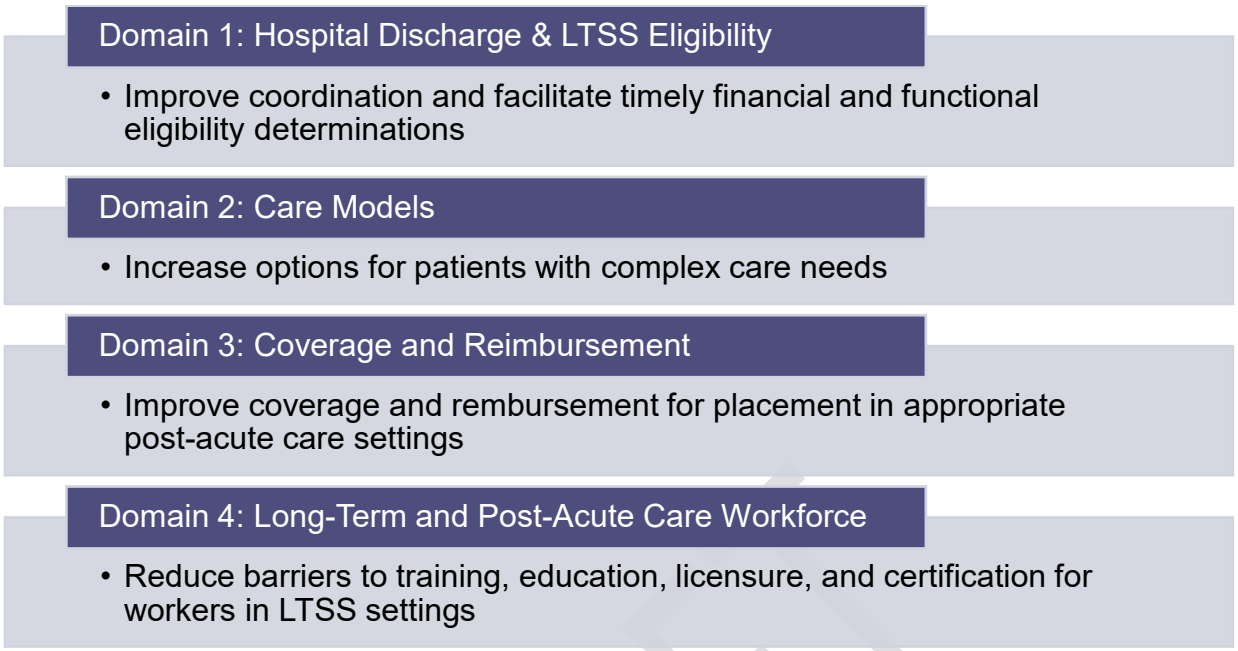
- **near-term strategies** needing only state authority and resources.
- **long-term strategies** requiring federal approval to secure regulatory authority or financial participation.

The Task Force developed strategies in four policy domains (see Exhibit 3). The measure also directed the Task Force to "consider how each recommendation [...] relates to the needs of individuals who are experiencing homelessness or who otherwise lack stable housing."[10]

[9] In this report and related analyses, housing insecurity is defined as "problems related to housing and economic circumstances" which may include being homeless or at risk of homelessness, living in a shelter or transitional housing, or living in housing that lacks utilities or adequate heating/cooling. This definition is drawn from ICD-10 codes used to identify housing insecure patients within health care claims data. See https://icd10cmtool.cdc.gov/?fy=FY2023&query=housing

[10] House Bill 3396 (2023)

Exhibit 3. House Bill 3396 Policy Framework (Four Domains)



Source: Legislative Policy and Research Office

The assembly provided the Task Force with time and resources to gather and analyze data from multiple sectors and to review strategies that have been successful in other states. With analytic support from the Legislative Policy and Research Office, consultants at ATI Advisory, and participating Oregon agencies, the Task Force began its work by assessing needs and opportunities within the policy framework (see Appendix XX).

Following the assessment and a status update to the assembly in December 2023[11], members agreed to a work plan including focused conversations for each domain in the HB 3396 framework (see Appendix XX). These focused conversations took place over many months, engaging both subject matter experts and members of the community to examine problems and discuss potential solutions.

Members agreed that solutions should be patient-centered (including for people who lack secure housing) and relevant to reducing discharge delays. Members resolved to develop recommendations that are specific and actionable and, in their words, avoid "passing the buck."

[11] Joint Task Force on Hospital Discharge Challenges, "Memorandum to the Interim Committees on Health Care and Human Services," December 12, 2023. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/279144

[date of finalization]

Domain 1: Streamlining Hospital Discharge and LTSS Eligibility Processes

The Task Force studied how individuals are being discharged from hospitals to post-acute and community-based care. This work focused on understanding 1) the role of state agencies when individuals need Medicaid coverage for long-term services and supports (LTSS) to access ongoing care after a hospital stay, and 2) the processes involved in locating an appropriate care placement or provider for individuals discharging from the hospital.

The Task Force identified several **key findings** impacting hospital-to-community care transitions, including:

- Medicaid LTSS eligibility assessment process and communication breakdowns are occurring among agencies, hospitals, post-acute providers, and clients;
- Staffing constraints are impacting the availability of caseworkers and public guardians; and
- Screening requirements for financial assets and functional needs create barriers to accessing Medicaid-paid LTSS.

The Task Force advanced **three recommendations** in Domain 1:

1. Update LTSS Eligibility Processes and Workflows
2. Waive or Streamline Asset Verification for LTSS
3. Increase Support for Legal Guardians

These Domain 1 recommendations are further explored in this section with additional background and analysis that informed Task Force discussions.

RECOMMENDATION #1: UPDATE LTSS ELIGIBILITY PROCESSES AND WORKFLOWS

The Task Force recommends the Legislative Assembly should direct the Oregon Department of Human Services (ODHS) and Oregon Health Authority (OHA) to take the following actions:

1. Create a dashboard to measure completion time of LTSS eligibility determinations across local offices of Aging and People with Disabilities (APD) and Area Agencies on Aging (AAAs).
2. Conduct an operational review to streamline LTSS assessments, with a report back to the Legislative Assembly no later than August 15, 2026, including:
    - A baseline analysis from the dashboard of average processing times for functional and financial assessment of individuals in acute and post-acute care settings;
    - Specific benchmarks, developed in consultation with providers and stakeholders, for improvement in processing times (i.e., number of days);
    - The target date for the agencies to achieve benchmarks for screening times;
    - Exploration of technologies, including automation of agency and provider workflows, to decrease processing times;
    - Workflows and staff assignments, including dedicated teams for complex LTSS cases, to meet benchmarks for functional assessments;
    - Published protocols for local caseworkers to intervene when delays occur in financial assessments; and,
    - A decision tree for hospital staff to navigate OHA and ODHS processes, including next steps once process options are exhausted.
3. Request approval from the Legislative Assembly to rebalance funding for staff assignments based on methodologies that account for the complexity of cases and clients without a paid provider.
4. Explore presumptive eligibility and advance payment for LTSS. Along with other strategies to meet benchmarks for screening times, the agencies should determine what resources and policies would be needed for the state to provide short-term, temporary LTSS coverage for clients who are presumptively eligible while full determination is pending. Presumptive

eligibility for LTSS should be based on a client's self-attestation that they meet Medicaid LTSS financial eligibility requirements. Agency analysis should include study of other state models, provider input, consideration of the regulatory and financial risks of PE on post-acute care settings, and options for short-, medium-, and long-term financial supports for clients who are unfunded or underfunded due to being found eligible for LTSS until a safe discharge can occur with technical support from the agencies.

Key Findings and Rationale for Recommendation 1

LTSS Screening Process and Communication Challenges

Determining a client's eligibility for Medicaid-paid LTSS, which is a separate process from basic eligibility for the Oregon Health Plan (OHP) medical coverage, can be a key step in the hospital discharge process. The Oregon Department of Human Services and the Oregon Health Authority share responsibility for this work (see Exhibit 4).[12]

Exhibit 4. Shared Agency Responsibility for LTSS Eligibility Screening

Mental Illness

- OHA oversees coverage for people 21 and older with a chronic mental illness who receive home and community-based care under the state's Medicaid 1915(i) waiver.

Physical, Intellectual, or Developmental Disability

- ODHS' Office of Aging and People with Disabilities (APD) oversees home and community-based care for people who need nursing facility levels of care, or who have an intellectual or developmental disability, under a 1915(k) state plan option as part of the Affordable Care Act (ACA).

Source: Legislative Policy and Research Office

When a hospital identifies a client needing LTSS, a referral is made to the appropriate agency to conduct the screenings needed to determine Medicaid LTSS

[12] De Jung, T., Weidanz, J.E. "Roles and Process Overview." October 17, 2023 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/277455

[date of finalization]

eligibility. Under federal law, LTSS eligibility determinations must be completed within 45 days.

The process of determining someone's eligibility for LTSS and obtaining community care is highly individualized depending on a client's needs. It can require consideration of a wide range of factors including substance use, limits in family or caregiver support, housing insecurity, behavioral challenges, or complex medical factors such as obesity that can affect delivery of personal care.[13]

Pandemic Disruptions

Standard LTSS eligibility determination processes were severely disrupted during the COVID-19 pandemic. ODHS and OHA implemented several temporary changes to streamline these processes during the public health emergency, including:

- In late 2021, an incident management team was established to address hospital capacity issues during the delta variant "surge", along with additional contract staffing to expand capacity of nursing facilities to accept patients from hospitals.
- In early 2022, a cross-agency unified command center was established that tracked patient discharges across regions and continued enhanced staffing agency support in hospitals, long-term care, adult foster homes, and behavioral health facilities.
- APD took additional steps including redeploying agency staff to assist with hospital discharges and embedding dedicated intake specialists in local hospitals.[14]

These emergency efforts wound down and discontinued as Oregon emerged from the pandemic and the federal public health emergency declaration expired on May 11, 2023.

Hospital Reports of Challenges

Task Force members elevated concerns that delays in LTSS eligibility determinations were contributing to delays in patients discharging from the hospital. For example, representatives from Providence presented a retrospective review of records from St.

---

[13] De Jung, T., Weidanz, J.E. "Roles and Process Overview." October 17, 2023 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/277455

[14] Weidanz, J.E. "House Bill 3396 Task Force." September 21, 2023 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/276867]

[date of finalization]

Vincent Hospital indicating LTSS eligibility determinations were averaging 22.83 days for their admitted patients, with patients' average length of stay (ALOS) exceeding what would be expected based on clinical characteristics. The process of securing an exception to pay a higher post-acute provider reimbursement for clients with complex needs was averaging 14.8 days.[15] Representatives from Samaritan Health Services reported challenges finding placements for patients who were awaiting LTSS eligibility determination, with post-acute facilities being reluctant to begin the process of admitting a client while their LTSS coverage was uncertain.[16]

Oregon is challenged to systematically assess discharge delays resulting from LTSS eligibility determinations because of limited data collection and monitoring capabilities across regions and hospital systems. OHA currently contracts with APPRISE Health Insights to capture information from hospitals. A public dashboard developed during the pandemic tracks delayed discharges over time.[17] The dashboard does not report reasons for delayed discharge, which are not systematically reported by hospitals.[18]

Consultant Research

ATI Advisory, a consulting services firm, was engaged to further study hospital discharge and agency LTSS eligibility processes and report findings to the Task Force. They interviewed stakeholders and reviewed agency administrative data and

[15] Moreno, R. "Hospital Capacity, Throughput, and Length of Stay." October 17, 2023 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/277458).

[16] Ogden, L. "Samaritan Health Services." October 17, 2023 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/277460).

[17] Apprise Health Insights. "COVID-19 Hospital Capacity" (dashboard). Available at https://public.tableau.com/app/profile/apprisehealthinsights/viz/COVID-19HospitalCapacity/DailyTrends

[18] Apprise shared information with the Task Force in May 2024 regarding efforts to capture reasons for discharge delays; a pilot project has developed preliminary protocols for reporting discharge delay reasons, with 32 of 61 hospitals contributing partial data beginning late November 2023. The process was still being developed at the time of the Task Force's work though may offer opportunities in the future for regional or statewide analysis.[18]

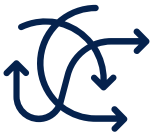
[date of finalization]

documents in early 2024. A complete discussion of findings is available in a separate report.[19] Key findings from their assessment[20] include:

Clients discharging from the hospital frequently have complex care needs such as co-occurring physical and behavioral health conditions. For example, among those discharged with serious mental illness (SMI), more than half were 65 or older with greater physical health needs.

The case manager workforce that completes LTSS determinations is experiencing challenges. More experienced case managers are increasingly leaving these roles and vacancies have trended upward over time while wages have fallen behind inflation. Caseload measures have remained stable, but the methodology for calculating caseloads does not account for complexity of clients (which is increasing over time) or for clients without a paid caregiver.

Average hospital lengths of stay in Oregon increased 27% from 2017 to 2022. People with complex care needs saw the largest increases in ALOS. For example, people with Alzheimer's or dementia-related diseases (ADRD) saw an average 38% increase in hospital length of stay during this period. These individuals also frequently discharge to settings that do not match their needs. For example, people with SMI who are homeless are frequently discharged to self-care.

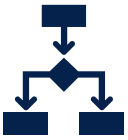


There are opportunities to address communication challenges or information gaps between hospital, LTSS case managers, and post-acute providers. For example, guidance may be needed to help stakeholders understand which care settings are appropriate for certain needs. Standards may be needed for case manager scheduling and response times. Stakeholders need clarification from agencies regarding the

[19] ATI Advisory. "Opportunities for Oregon to Promote Timely and Appropriate Hospital Discharge for Individuals with Complex Care Needs. August 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/285184

[20] ATI Advisory. "Assessing Oregon's Hospital Discharge Processes and Experiences – Challenges and Opportunities." May 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283993

different eligibility processes for people with mental illness or physical disability.



Changes to LTSS eligibility assessment processes could reduce delays. For example, process improvements could focus on initiating eligibility determinations sooner following hospital admission and additional supports to caseworkers. Operational agreements between Coordinated Care Organizations (CCOs) and local LTSS eligibility offices could support system coordination for people enrolled in Medicaid.

Agency Initiatives

These challenges have been the focus of concurrent agency process improvement efforts underway as the Task Force completed its work. Oregon operates under a variety of federal waivers and state plan options that shape the delivery of Medicaid services. The state's 1915(k) state plan option and 1915(i) waiver together enable the state to provide home and community-based services to various populations, though there are different eligibility criteria and funding streams depending on the population and these programs have developed in silos.

OHA serves people diagnosed with a chronic mental illness using the 1915(i) waiver. ODHS serves people who are aging and who have disabilities under the 1915(k) state plan option but may not serve people whose primary need is for mental health care. People with co-occurring needs can become stuck when it is unclear which agency is responsible for their coverage and care.

ODHS and OHA provided an update on these efforts in September 2024,[21] noting:

- An assessment from October-December 2023 confirmed challenges arising between APD's 1915(k) and OHA's 1915(i) eligibility processes for people who apply for Medicaid LTSS coverage.
- The agencies conducted a national scan of other states' approaches, internal planning conversations, and community engagement sessions in early 2024 to inform development of a future state vision and roadmap for improving Home and Community-Based Services (HCBS) delivery.

[21] Heiberg, H., Weidanz, J.E. "Current and ongoing cross-agency work regarding 1915 services and screening processes: enhancing home and community-based services access roadmap." September 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/285266

[date of finalization]

- The goal is to move toward an integrated system for eligibility determinations across the different programs, with screening tools and workflows that create a more seamless experience for clients and caseworkers.
- Phase 1 of the work (currently underway through June 2026) includes agency change management plans, recruitment, and retention strategies, developing a capacity dashboard and adopting new documentation systems. OHA and ODHS are leveraging remaining federal American Rescue Plan Act (ARPA) funds for these efforts.
- Phase 2 of the work (through June 2027) will include, in part, a review of administrative rules and waivers, evaluating information exchange across the agencies, and developing a shared regulatory framework. The agencies have advanced a policy option package and budget request for the 2025-27 legislative session to support this work.

The agencies' roadmap envisions a future system where individuals with behavioral health needs could access both the 1915(i) and 1915(k) systems seamlessly.

Presumptive Eligibility for LTSS

The Task Force explored presumptive eligibility (PE) as another option to shorten the time frame for an individual to be able to discharge from the hospital to Medicaid-paid LTSS. PE is a way to assess if a person appears to be eligible for certain services, and then allow payment to begin for those services, pending completion of the full eligibility verification process.

States are already required to implement presumptive eligibility for hospital care under the Affordable Care Act. Under this approach, hospitals can determine if an individual appears to be eligible for Medicaid or the Children's Health Insurance Program (CHIP) and enroll them. Coverage begins immediately and continues until the state completes the full eligibility verification. Generally, if a person is later determined not to be eligible, the provider is not responsible to refund claims paid for services during the PE period.

The Task Force explored whether Oregon could implement PE for LTSS as it has done for hospital care. The process is more complex because eligibility for Medicaid-paid LTSS follows a different eligibility pathway than for hospital care. Where hospital PE is typically based on Modified Adjusted Gross Income (MAGI) criteria such as income and citizenship, LTSS eligibility involves both a financial screening (with asset verification and a lookback period) and a functional needs assessment and care plan.

A review of states in early 2024 found nine states have received federal approval to implement PE for LTSS, while another six have implemented other "fast track" procedures for accelerated application processing.[22]

ATI Advisory gathered information on state PE approaches in Oregon's neighbor states for the Task Force, finding:[23]

- **Washington** established a PE process for two of its waiver-funded home and community-based services programs.
- **California** pursued a Section 1115 waiver to allow LTSS PE for people who are 65 or older, not eligible for Medicare, and with incomes at or below 138% of the federal poverty level.

ATI Advisory and ODHS advised the Task Force of certain considerations for Oregon. First, section 1115 waiver negotiations are time consuming. Centers for Medicare and Medicaid Services (CMS) has a queue of pending waiver requests and may be unlikely to review additional requests in the next year. Waivers also must be budget neutral to the federal government. As such, this policy concept is not a near-term option to expedite LTSS determinations but rather a longer-term approach to streamlining the process.

New operational processes must be developed to demonstrate to CMS that a program can be implemented. These processes can include training new qualified entities to conduct PE authorizations that meet CMS requirements, including the functional assessment requirement. An additional consideration is that if PE creates an entitlement to short-term LTSS, and someone is later determined ineligible, the person could appeal the determination. The case would need to go through due process with an administrative judge before their case could be closed. Other states that have implemented PE have defined the LTSS coverage narrowly and allowed a limited time to verify eligibility to limit risk exposure.

---

[22] MACPAC. "Compendium on Medicaid Eligibility Policies Affecting the Timeliness of Access to Home- and Community-based Services." August 2024. Policy in Brief. https://www.macpac.gov/wp-content/uploads/2024/08/Compendium-on-Medicaid-Eligibility-Policies-Affecting-the-Timeliness-of-Access-to-Home-and-Community-Based-Services-1.pdf

[23] ATI Advisory. "Analysis of Benefits, Coverage, and Payment Policy for Post-Acute Care." June 27, 2024 presentation. *https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284676*

Member Considerations

Over the course of several meetings, members discussed how improvements in eligibility processes could help to address delays in patients discharging from hospitals. Key points across these discussions included:

- How the current siloing of administrative programs is very difficult for both agency and hospital case managers to navigate. These processes, as designed, cause challenges for everyone involved.
- The eligibility processes have developed over time in response to both federal and state requirements. Renegotiating federal agreements will be necessary for some of the improvements the Task Force is interested in seeing, though this is a multi-year process. There is urgency to address any changes that can be made at the state or county level as soon as possible.
- It is important to consider the workforce who will be responsible for implementing changes in these processes. The APD and AAA case manager workforce is spread thin and asking them to expedite processes or absorb additional case management work related to behavioral health clients will be challenging without other supports.
- It is important for caseworkers to attend care planning meetings between payers and providers to ensure successful coordination of care and services, including those provided by CCOs.
- Hospital staff should have clear insight into ODHS and OHA processes, including a protocol for next steps when standard steps in the process are exhausted.

Members considered these issues, in addition to the analyses detailed here, in developing their recommendation to streamline LTSS processes. Member discussion of presumptive eligibility also occurred over several meetings with consideration of the following points informing the Task Force recommendation:

- Establishing PE for LTSS is unlikely to alleviate providers' concerns about accepting patients with complex needs unless the provider would be held harmless if a PE client was later determined ineligible for full LTSS. There is a need to develop a framework for financial risk sharing and seek provider input on whether it would be effective. This would also include discharge options from post-acute care. Even with this protection, providers may be reluctant to accept PE clients because of the potential for financial losses if a PE client is denied full LTSS coverage but cannot be discharged due to a lack of an appropriate discharge destination (for example, if a client is homeless).

- Oregon agencies should explore how other states have designed presumptive eligibility coverage, including advanced payment models, and consider strategies to enable PE for specific priority populations. Allowing PE for patients with fewer placement barriers (e.g., those discharging to home) may allow caseworkers more time to screen and place more complex patients with greater barriers.
- In the absence of a federal waiver, services provided under PE coverage would be state paid. There is a need to understand these potential costs, based on specific assumptions about how the state would design the benefit and who would be eligible.

The need for additional data collection and modeling of costs and enrollment outcomes informed the Task Force recommendations on presumptive eligibility and asset testing.[24]

[24] Legislative Policy and Research Office. "Joint Task Force on Hospital Discharge Challenges Meeting #9." June 27, 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284907

RECOMMENDATION #2: WAIVE OR STREAMLINE ASSET VERIFICATION FOR LTSS

The Task Force recommends that the Legislative Assembly direct OHA and ODHS to study options to waive or streamline asset testing for LTSS, including studying financial and equity impacts, and report back to the Legislative Assembly no later than December 31, 2025, with a plan to seek federal approval.

Asset testing policies should, to the extent possible, expedite assessment and allow self-attestation of financial eligibility for people who are homeless or who receive subsidized housing, food assistance or other qualifying income-tested benefits.

Key Findings and Rationale for Recommendation 2

The process of applying for LTSS involves several steps, including both financial and functional needs screenings. Delays can occur in any of these steps, contributing to delays in people gaining coverage for LTSS that they need to discharge to post-acute care. The Task Force explored where the state could seek federal approval to simplify or streamline its asset verification steps of the LTSS eligibility process.

People who can be subject to financial asset verification include older adults (65 and older) and people who are blind or disabled. States have variable thresholds and criteria for which assets can be counted when determining LTSS eligibility, including cash or investments, as well as property (real-estate, etc.).[25] Most states, including Oregon, establish a limit of:

- No more than $2,000 in assets for a single person;
- No more than $3,000 in assets for a married couple, or
- Up to $154,140 for a married applicant under the Community Spouse Resource Allowance (CSRA).

The asset verification process includes reviewing documents such as bank or retirement account statements. The time period of review, called the "look-back

[25] Musumeci, M.B., O'Malley Watts, M., Ammula, M., Burns, A. *Medicaid Financial Eligibility in Pathways Based on Old Age or Disability in 2022: Findings from a 50-State Survey.* July 11, 2022. KFF. https://www.kff.org/report-section/medicaid-financial-eligibility-in-pathways-based-on-old-age-or-disability-in-2022-findings-from-a-50-state

period", spans the 60 months (5 years) prior to the date of application. The agency reviews an individual's assets during this period. Asset transfers made during the lookback period can be disqualifying.

The asset verification process can be time consuming and may pose particular challenges for individuals who are cognitively impaired or have behavioral health conditions, are experiencing homelessness, or lack social supports or a legal guardian to assist in the process.

In recognition of these challenges, some states have requested federal approval to make changes to the asset verification process. These models include:

- **Increasing or eliminating the asset limit.** States such as New York and Vermont have used Section 1115 waiver authority to increase the overall asset limit for individuals or couples. California eliminated its asset limit.
- **Shortening the lookback period.** New York used Section 1115 authority to shorten its lookback period for asset verification from 60 months to 30 months.
- **Streamlining the verification process.** New Jersey used Section 1115 authority to permit individuals with incomes below 100% of the federal poverty level to self-attest that they have not transferred assets during the lookback period.

ATI Advisory compiled additional details on these state approaches.[26] They advised the Task Force that:

- Changes require federal negotiations, which are time consuming and labor intensive, and subject to federal approval.
- This issue would benefit from analyzing data to understand more specifically where people may become delayed in the asset verification process, or what circumstances are most often disqualifying; ODHS and OHA may be able to make administrative or operational changes in the near-term without a waiver that could simplify the asset test process.
- Given that federal waivers must be budget neutral, analysis would be needed to model how the population of eligible people would change under different asset testing scenarios. There may be ways to tailor asset test changes to target specific challenges in the current process.

[26] ATI Advisory. "Analysis of Benefits, Coverage, and Payment Policy for Post-Acute Care." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284676)

Member Considerations

Members considered how these concepts could address discharge challenges in Oregon. Key considerations included:

- The asset testing process can delay access to care even when a person is eligible. Members noted these processes largely date back to the 1980s and are inconsistent with current state and federal goals to improve access and reduce inequities in care. There would be clear societal benefits to updating Oregon's approach.
- Additional modeling work would be an important first step for Oregon since the Task Force did not have access to any estimates of population or fiscal impact of any potential changes.
- Simplifying the state's asset test limits and process should be a priority for the next round of federal waiver negotiations. The agencies could study options and potential impacts now to inform early planning for those negotiations.
- Eligibility for income-tested benefits including subsidized housing and Supplemental Nutrition Assistance Program (SNAP) could help expedite or eliminate the need for asset testing.

RECOMMENDATION #3: INCREASE SUPPORT FOR LEGAL GUARDIANS

The Task Force recommends that the Legislative Assembly should permanently fund the five (5) OPG positions established in 2024.

The Task Force recommends that OPG, in consultation with community partners, develop a proposed approach to provide grants to community-based organizations to deliver guardianship services following established guardianship standards, with the additional resources needed to perform audits. OPG should seek resources and authority from the Legislative Assembly as needed to:

- Administer grants to community-based guardianship services for individuals needing placements in appropriate settings; and
- Administer grants for legal costs (attorney fees, filing costs) and training for friends and family who can serve as guardians, following established guardianship standards.

Key Findings and Rationale for Recommendation 3

Clients may need support with decision making about their care and do not have a family member or close personal contact who can assist or make decisions on their behalf. The Task Force reviewed information about **two options** in these cases:

- Supported decision making.
- Legal guardianship.

Information about these options and related analysis are below.

Supported Decision Making

The Task Force received background on supported decision making from Oregon's Office of Developmental Disability Services (ODDS). Supported decision making (SDM) is one of the least restrictive forms of alternative decision making and can be considered a default option for people needing decision support, though the option is sometimes overlooked in favor of more restrictive options.

SDM is an evidence-based approach that involves getting support from trusted family or friends to gather information, evaluate options, and communicate

decisions. The person remains the ultimate decision maker (in contrast to guardianship, where a guardian may overrule an individual's decision).[27]

Families are often unaware that SDM is an option. Structures and frameworks for SDM also exist within social service delivery systems but are not commonly recognized as an accommodation by other entities like courts, doctors, schools, banks, etc. In recognition of this challenge, federal and state laws increasingly highlight SDM, including the uniform code on guardianship, to ensure it is explored before more restrictive options. In Oregon, ORS 127.635, relating to health care representatives, outlines a hierarchy of which individuals may serve as a surrogate decision maker for purposes of withdrawing life-sustaining procedures. There is not a similar Oregon statute relating to hierarchy of surrogate decision makers for LTSS.[28]

Legal Guardianship

In contrast to SDM, guardianship is a legal process by which a court appoints a friend, family member, or professional who is willing to serve as guardian, making decisions on behalf of individuals who lack capacity. The process of becoming a legal guardian includes filing fees and court appearances. Even when a friend or family member is available to serve as a guardian, they may need training and financial support for legal costs. The Task Force heard about two models in Oregon for guardianship services, detailed below.

Oregon Public Guardian

The Oregon Public Guardian and Conservator is an independent public program within the Office of the Long-Term Care Ombudsman providing guardianship services for people for whom there is no less restrictive alternative for decision making, no one willing to serve as the person's guardian, and no financial resources to hire private guardianship services. OPG assists individuals in applying for and receiving Medicaid long-term services and supports and behavioral health services. OPG also assists individuals discharging from the Oregon State Hospital and those

[27] Enriquez, A. "Supported Decision-Making." December 12, 2023 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/278819

[28] SB 1606 (2020) recognized the right to have a support person present while in the hospital as an accommodation to gain access to existing rights to health care and to ensure effective communication.

who have been detained by law enforcement but are temporarily or permanently unable to "aid and assist" in their own defense.

OPG shared information with the Task Force about individuals who receive services:

- As of December 2023, 53% of clients referred to OPG were in the hospital but unable to safely discharge at the time of referral; 54% of clients were homeless; and 27% had been abused or neglected. Most cases require a large amount of assessment work during the intake process and this process can take several months.
- OPG can request 30-day emergency guardianship for people who become stuck in hospitals, having established through court proceedings that individuals are at risk of medical decompensation in these situations. This emergency status can be initiated to begin hospital discharge coordination while also working on indefinite guardianship (which takes longer).
- As of December 2023, OPG employed 13 positions including one deputy guardian position temporarily funded by a grant from Asante Health Network. The office has caseload capacity for up to 180 clients with a current waitlist of 65 clients. A volunteer program launched in 2022 supported 11 clients through ten certified volunteer public guardians. An estimated 500 or more individuals in the community may have unmet needs for guardianship and many more may need less restrictive forms of supported decision making.
- The office is statutorily limited to guardianship or conservator services. The office could be statutorily expanded to offer supported decision making or other services such as representative payee (i.e., to manage Social Security Disability or Supplemental Security Income payments on behalf of a client).
- Following the OPG presentation to the Task Force in December 2023, the 2024 Legislative Assembly funded five additional positions through the 2025 biennium.

Community-Based Services

The Task Force received information about community-based nonprofit guardianship services from the Central Oregon Guardian Assistance Program (COGAP). COGAP provides pro-bono and sliding scale guardianship, representative payee, and other legal services in Central Oregon. Information included:

- Some referrals are from St. Charles and others are from a circuit court for people who are detained with aid and assist orders. Most of the people they serve transition to memory care or adult foster homes.
- COGAP contracts with St. Charles Health System to provide legal aid in guardianship petitions for patients who are hospitalized. Their intake process

is similar to OPG but overseen by a five-person advisory committee. They work closely with OPG as both entities provide services in their region.

- COGAP is also working with Central Oregon Community College and Oregon State University Cascades to create a guardianship certification program modeled on the University of Washington's nine-month certification program. COGAP intends to provide internship opportunities and mentorship to students in the certification program. Becoming a professional certified fiduciary, including the training and exam, costs roughly $10,000. COGAP also plans to provide scholarships to offset this cost though this will depend on fundraising efforts.

Member Considerations

The Task Force discussed options to address the need for guardianship and decision-making support for people who are cognitively impaired and waiting to be discharged from the hospital. Key points considered included:

- Hospitals have seen an increase over time in the number of patients needing guardianship services before an application can be initiated for Medicaid LTSS for placement in memory care. These patients can become stuck in the hospital for 90-100 days after they no longer need hospital care.
- Memory care facilities may be requiring that guardianship services are in place before accepting a client from a hospital, though this is not a regulatory requirement. Formal guidance may be needed from the state to clarify regulations, though facilities may also be following internal policies.
- Hospitals such as Asante have paid private guardians to assist patients with this process when public guardians are not available. Associated costs can include attorney fees as well as the uncompensated care an individual receives while awaiting guardian appointment. In recent years, OPG received legislative approval to apply short-term funding from Asante for an additional deputy guardian for the region, which has helped with delays.
- The OPG positions funded during the 2024 legislative session were hired and began providing services. Legislative action would be needed in the 2025 session to make these positions permanent.
- In addition to OPG, community-based providers including COGAP—as well as friends and family—are important points of access to guardianship across the state.

Domain 2: Innovation in Care Models

Most post-acute care in Oregon is received in home and community-based settings (see Exhibit 5). HB 3396 directed the Task Force to consider how to increase options for community-based placements for post-acute care, including exploring innovative care models for people with complex health needs or who lack stable housing. The bill defined post-acute care to include:

- **Home and community-based service (HCBS) providers**, including in-home personal care services; adult foster homes (AFH), and residential care facilities (RCF) (inclusive of assisted living (ALF) and memory care); and
- **Institutional and outpatient medical care providers**, including home health care agencies; skilled nursing facilities; and community hemodialysis providers.

Settings such as residential treatment facilities for people with a primary behavioral health need were not included, though members noted these settings are also an important component of the post-acute continuum of care for people with complex medical or housing needs.

The Task Force gathered information about

- the current regulatory model for post-acute providers, and
- key challenges impeding the delivery of care to people transitioning from hospitals.

Exhibit 5. Post-Acute Care in Oregon, by the Numbers

- 17,000 Home Care Commission workers
- 1,354 adult foster homes
- 224 memory care facilities
- 336 residential care and assisted living facilities
- 131 nursing facilities
- 186 in-home care agencies

Source: 277943 (oregonlegislature.gov)

The Task Force advanced two recommendations in Domain 2:

4. Refine the Regulatory Framework to Support Complex Care
5. Expand Medical Respite Programs Statewide

These Domain 2 recommendations are further explored in this section with additional background and analysis that informed Task Force discussions.

RECOMMENDATION #4: REFINE THE REGULATORY FRAMEWORK TO SUPPORT COMPLEX CARE

The Task Force recommends that the Legislative Assembly should direct the Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA) and provide resources to study regulations for post-acute and long-term care facilities with residents presenting complex medical and behavioral health conditions. The study should:

- Identify any regulatory changes that are needed for licensure of "step-down" facilities for patients with complex care needs that neither require hospitalization nor are appropriate for skilled nursing.
- Assess whether existing Enhanced Care Services and Special Needs Contracts could meet these needs, and the steps and resources that would be necessary to expand these services statewide.
- Detail the public and private sector workforce needed to implement any proposed expansion of Enhanced Care Services or other specialized contracts or new step-down models.
- Determine how separate licensing requirements for community-based care, particularly foster homes serving clients of the Office of Aging and People with Disabilities (APD), the Office of Developmental Disability Services (ODDS), and OHA, serves the needs of patients needing complex care.
- Review the use and impact of civil monetary penalties and develop recommendations for technical assistance or agency guidance before civil monetary penalties apply.
- The report should be made to the Legislative Assembly no later than August 15, 2026.

[date of finalization]

Key Findings and Rationale for Recommendation 4

Current Regulatory Oversight

The Task Force reviewed information on how Oregon's post-acute providers are currently regulated.[29] Of the facilities listed above:[30]

- **Adult foster homes** are primarily regulated at the state level through administrative rules enforced by local APD offices and Area Agencies on Aging (AAA). They are licensed annually. These rules were largely developed in the 1990s following a series of negative events.
- **Community-based care facilities (CBC)** (including assisted living and residential care) are primarily regulated at the state level by ODHS' Safety, Oversight and Quality (SOQ) program and licensed every two years. These requirements are also largely established through state administrative rule, though the state cannot change the federal HCBS requirements related to individual resident rights.
- **Nursing facilities (including memory care)** are primarily federally regulated by the Centers for Medicare and Medicaid Services (CMS). SOQ staff trained by CMS oversee annual licensing. The state has very little flexibility to make changes in this area.

The regulatory framework followed by SOQ (see Exhibit 6 for details) is intended to be progressive, relying first on technical assistance to resolve disciplinary issues before moving to corrective action.[31] SOQ also operates a Facility Enhanced Oversight and Supervision program for facilities with recurring compliance issues. In considering rule changes recommended by the Task Force, SOQ would consider how a proposed change would impact protection of residents from harm and support providers in delivering quality care to consumers.

[29] Legislative Policy and Research Office. "Joint Task Force on Hospital Discharge Challenges Meeting #8." May 23, 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284680

[30] Honey, J. "Safety, Oversight and Quality Unit Survey / Regulatory Overview." May 23, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283944

[31] Honey, J. "Safety, Oversight and Quality Unit Survey / Regulatory Overview." May 23, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283944

Exhibit 6. Regulatory Oversight by Provider Type

Provider Type	Regulatory Processes
Adult Foster Homes	Adult foster home regulation by local APD/AAA staff can include complaint investigation, license renewal/monitoring, corrective action oversight, or other check-ins as needed.[32] Regulations span the following areas: • Facility standards • Caregiver staffing • Resident records • Medication and treatment standards
Community-based Care	CBCs are regulated through surveys and site visits for licensing renewal (every 2 years), kitchen inspections (annually), and revisits if a facility is found to be out of compliance.[33] Teams of 2-5 surveyors visit the site for 4-5 days to make observations, conduct interviews, and review resident records. CBCs with licensing violations receive a statement of deficiencies with a description of each violation. They are required to develop a correction plan. The survey team may impose civil financial penalties or other conditions depending on violations.
Nursing Facilities	Nursing facilities are regulated through an annual federal survey process for licensing renewal, and for abuse and complaint investigations.[34] A team of 3-4 surveyors from SOQ conduct on-site visits for approximately one week to observe, conduct interviews, and review resident records. Federal survey standards are outlined in the CMS State Operations Manual for Nursing Facilities and additional state administrative rules. Facilities with license violations receive a statement of deficiencies, are required to develop a corrective action plan, and may be subject to federal and state civil penalties.

Source: Legislative Policy and Research Office

[32] Id.
[33] Id.
[34] Id.

Understanding Common Provider Challenges

The Task Force heard from providers regarding challenges impacting their capacity to accept patient referrals from hospitals.[35] It was noted that the most common reason for a post-acute facility denying referral from a hospital was the client being inappropriate for the referred setting, often due to dangerous behaviors, active substance use, or the need for frequent monitoring requiring additional staff.[36]

Post-acute providers reported facing similar challenges to hospitals in that clients without stable housing can become "stuck" with the post-acute facility if they cannot be discharged home when they no longer need care. Under existing statute, facilities can issue 30-day and less-than 30-day involuntary move out notices to residents for reasons including:

- non-payment,
- failing to disclose sex crime conviction,
- when care or behaviors pose a danger to the resident or others, or
- loss or suspension of the facility's license.

However, involuntary move-out notices must have a safe discharge plan and location. In nursing facilities, residents who have been in a facility for 30 or more days and are discharged have the right to be readmitted for 180 days. The facility is not required to hold a bed open, but if a bed is available, the facility is required to offer it to the former resident.

ATI Advisory conducted a statewide study to understand post-acute providers' capacity to care for people with complex needs across Oregon.[37] They identified overarching gaps in Oregon's existing post-acute care system that span different LTSS provider types, confirming that challenges reported by members are being experienced by providers across all regions of the state (see Exhibit 7).

[35] Bentley, P., Burns, E., Hilty, L. "Post-acute care system overview and capacity considerations." November 16, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/277943

[36] Id.

[37] This work included a survey of post-acute providers, analysis of the Oregon Health Care Workforce Reporting Program data, key informant interviews, and additional literature review. Full analysis available at https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283839.

Exhibit 7: Gaps and Opportunities in Oregon's Post-Acute Sector

Challenges	Overview	Opportunities
Regulations and payments	Providers perceived the regulatory and payment environment as limiting their ability to provide care to individuals with complex medical or social needs.	OHA and APD's **Enhanced Care Services** program serves people with complex needs but is only operating in 6 out of 36 counties in Oregon. Oregon's **adult foster homes** are separately licensed for people with physical, behavioral, or developmental disabilities despite clients having co-occurring needs.
Training and wages	Additional supports are needed to bolster the post-acute workforce that cares for people with complex medical and social needs.	The state can develop **specialized roles** for direct care workers with enhanced training in complex care or certifications in behavioral health that could help address system gaps. Increasing the minimum wage for workers or establishing a Medicaid rate pass-through could **raise direct care worker wages**.
Discharge options for complex care	Additional post-acute discharge options are needed for individuals with complex needs who are not being served by common post-acute models of care.	The state can expand access to new models of care like **medical respite care** for people who are homeless (sometimes called recuperative care or shelter care).

Note: More detailed findings and consultant recommendations may be found in ATI Advisory's September 2024 report to the Task Force available at Opportunities for Oregon to Promote Timely and Appropriate Hospital Discharge for Individuals with Complex Care Needs (oregonlegislature.gov)

Adult Foster Homes reported the fewest barriers to accepting clients with complex health or social needs, including homelessness or housing insecurity. Interviews with these providers also revealed they were the most consistently willing to accept clients with complex needs discharging from hospitals. However, these providers are separately licensed to serve people with physical, behavioral health, or intellectual and developmental disabilities (IDD), despite clients often having co-occurring needs.[38] AFHs receive different reimbursement levels depending on their licensure

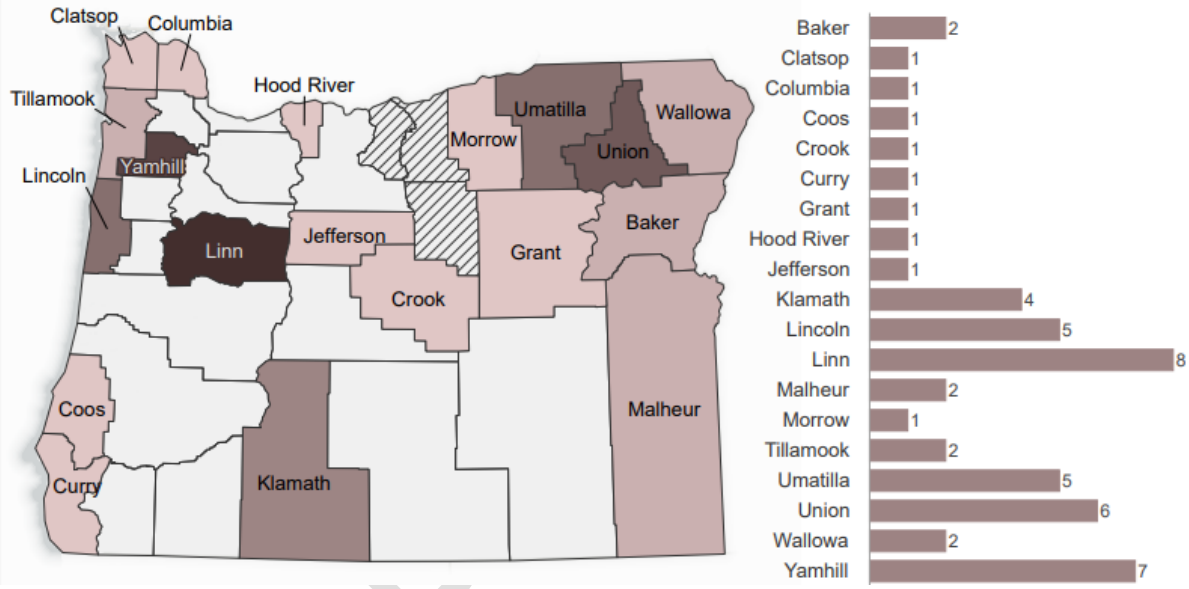
[38] Legislative Policy and Research Office. "Joint Task Force on Hospital Discharge Challenges Meeting #9." June 27, 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284907

[date of finalization]

type, and members noted that this variation in rates drives AFH providers to pursue licensure as IDD foster homes rather than becoming Behavioral Health or APD foster homes.[39] This has contributed to the state freezing applications for IDD foster homes while experiencing a shortfall of other AFH provider types.

ODHS leveraged federal American Rescue Plan Act (ARPA) funds during the COVID-19 pandemic to conduct targeted recruitment of new foster home providers in underserved areas. There were 1,389 APD adult foster homes operating across the state as of May 2024, an increase of 346 from early 2024.[40] However, this is below ODHS' target of 1,441 foster homes (based on a target of one bed per every 8 LTSS clients in each county). According to this target, ODHS reported an additional 52 APD foster homes are needed.[41] See Exhibit 8.

Exhibit 8. Additional APD Foster Homes Needed, by County, May 2024



Source: Legislative Policy and Research Office

Data: Oregon Department of Human Services: Aging and People with Disabilities

The Task Force also considered how payment and workforce challenges impact AFH providers; these analyses and related recommendations are described on p. XX.

[39] Id.

[40] Legislative Policy and Research Office. "Expansion of APD Adult Foster Homes." July 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284902

[41] Legislative Policy and Research Office. "Expansion of APD Adult Foster Homes." July 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284902

[date of finalization]

Expanding Specialized Care Settings

Task Force members identified certain existing care models that are offered by the state on a limited basis but may be scalable to serve a larger population of higher acuity clients. These include ODHS' Specific Needs Contracts (SNC) and contracts for Enhanced Care Services (ECS) (see Exhibit 9 for details).

Exhibit 9. About Specific Needs Contracts and Enhanced Care Services

Contract Type	Characteristics
Specific Needs Contracts	• A type of **contract** APD may approve to reimburse AFHs, RCFs, and ALFs* at a higher level of care for an individual client when their complex needs exceed what the facility would typically offer. • Residents must be eligible for Medicaid LTSS and meet **criteria,** including residing in or being diverted from a nursing facility, needing 24/7 support for physical or behavioral conditions, and presenting with bariatric, complex medical, behavioral, dementia, HIV/AIDS, hospice care, traumatic brain injury, or ventilator care needs. • Contracts impose additional **staffing** requirements on participating facilities (such as on-site behavioral health staff).
Enhanced Care Services	• APD may **contract** with an RCF or NF to become an Enhanced Care Facility (ECF). ECFs maintain four or more hours of on-site mental health services daily. Enhanced Care Services (ECS) are reimbursed at a higher rate to account for additional staff and more intensive physical and behavioral care needs of residents. • Residents must meet **criteria** including eligibility for Medicaid LTSS and APD services, a diagnosis of serious mental illness, history of recent Oregon State Hospital or extended inpatient psychiatric care (14+ days) and need for intensive rehabilitative mental health care. • Contracts impose **staffing** requirements including that ECFs must have an on-site Qualified Mental Health Professional and access to psychiatric consultation.

**Note on acronyms: Adult Foster Home (AFH), Residential Care Facility (RCF), Assisted Living Facility (ALF), Nursing Facility (NF)*

Source: ATI Advisory

ODHS negotiates payment rates at the facility level for both ECS and SNC arrangements. There are similarities and differences between the **payment models**:

- Both types of contracts pay a negotiated per-client rate to the facility. Specific Needs Contract rates are based on the target group served (e.g., for people with bariatric, dementia, ventilator care needs). Enhanced Care Services rates are based on the facility type ($21,335 per client for nursing facility units versus $17,678 per client in RCFs).
- Specific Needs Contract rates do not include behavioral health care, which is reimbursed separately on a per-service basis by OHA. In contrast, behavioral health care is incorporated into the per diem rate a facility receives for Enhanced Care Services.

Additional details on the SNC and ECS payment methodologies and rates are available in ATI slides from October 2024 (see Appendix).[42]

Standardizing and Scaling SNC and ECF

ATI Advisory gathered additional detail regarding SNC and ECS and noted that Oregon could promote timely hospital discharges by expanding these services.

> "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."
>
> –ATI Advisory (October 15, 2024 presentation to the Task Force)

At members' direction, additional information was gathered on what would be needed for state agencies (ODHS and OHA) to standardize and scale these models statewide. ATI interviewed stakeholders, identifying certain challenges and opportunities (see Exhibit 10).

[42] ATI Advisory. *"Scaling and Standardizing Specific Needs Contracts and Enhanced Care Services in Oregon."* October 15, 2024 presentation. Available at https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/286333

Exhibit 10. Challenges and Opportunities with SNC and ECS Contracts

	Consultant Findings	Stakeholder-Identified Opportunities
Survey and licensing requirements	• APD services exclude people with a primary BH diagnosis. OHA lacks capacity to serve these individuals who are often placed in SNC settings that cannot adequately pay for or manage their BH services. • Licensing requirements and wait times are cited by providers as a financial and administrative barrier to entering the market.	• Remove the APD exclusion on individuals with a primary BH diagnosis and pursue federal and state flexibilities to better reimburse BH services in SNC settings. • Update licensure process for facilities seeking SNC or ECS status (including review of other states' approaches).
Payment adequacy and methodology	• SNC providers struggle to maintain BH staff under per-service payments; rates have not kept pace with inflation. • SNC and ECS providers cannot directly hire QMHPs and must work through local mental health agencies; BH payments flow through OHA's Medicaid waiver rather than APD's 1915(k) waiver. • Bed holds and unpredictable census levels undermine providers' planning for staffing.	• Conduct a rate study that includes a forecast of the population served by ECS and SNC providers. • Increase rates for BH, SNC, and ECS providers and work toward payment parity across OHA and APD to ensure providers hire needed staff. • Assess bed hold policy and streamline contracting and placement to promote predictability in census levels.
Assessment tools, processes, and communication	• OHA and APD client assessment tool does not adequately capture needs, varies between agencies resulting in duplication and discrepancies. Rushed assessments lead to inappropriate placements that can cause clients to "churn" back to the emergency department.	• Update and align assessment tool and processes across agencies.* • Train discharge planners on need for communication and transparency about client complexity.

**Note: OHA and ODHS submitted a Joint Policy Option Package for the 2025 legislative session addressing this finding. See https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/285266*

Source: ATI Advisory. "Scaling & Standardizing Specific Needs Contracts and Enhanced Care Services in Oregon." Presentation to the Task Force on October 15, 2024. Available at https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/286333

[date of finalization]

ATI Advisory outlined next steps Oregon could pursue if interested in expanding access to SNC or ECS-funded services. These included:

- **Agency Opportunities.** OHA and ODHS (APD) can expand the training offered to discharge planners and SNC/ECS providers and promote technical assistance over corrective penalties. The agencies can pursue improvements in the assessment tools in use for client referrals. A rate study and scan of state licensing requirements for providers can inform agency efforts to recruit and retain SNC and ECS providers.
- **Legislative Opportunities.** Oregon's Legislative Assembly can ensure adequate agency staff for the initiatives described above. The Assembly can pursue rate and payment model updates for BH providers and SNC/ECS providers. The Assembly can provide statutory authority to enable OHA and ODHS to better collaborate to provide behavioral health services in SNC and ECS settings.

Additional details on these suggested next steps may be found in ATI presentation materials from October 15, 2024.[43]

Member Considerations

Members discussed options to expand access to care for people with complex needs, with consideration that:

- All facilities are required to consider certain factors when admitting a new resident, including the ability to meet that resident's needs as well as how admission would impact residents already within the facility. Facilities with SNC are subject to additional oversight and must run admissions through their contract administrator prior to approval.
- Many of Oregon's post-acute settings were not designed for the kinds of complex care they are currently asked to deliver. Providers reported concerns that accepting clients with complex behavioral health or substance use disorder needs could lead to regulatory penalties when these clients or others around them cannot be kept safe. Increasing provider rates in the absence of regulatory changes may not yield the desired improvements in access to community-based placements.

[43] ATI Advisory. *"Scaling and Standardizing Specific Needs Contracts and Enhanced Care Services in Oregon."* October 15, 2024 presentation. Available at https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/286333

- There is a missing intermediate level of care within the continuum for clients with complex behavioral or social needs who need to "step down" from hospital to community-based care. The current SNC and ECS appear able to fill this gap if these programs could be implemented statewide.
- Providers have requested ODHS and OHA review current agency regulations to understand where changes would support post-acute facilities to remain in compliance when admitting these clients. SOQ indicated this review could be done.
- The executive branch, with leadership from the Governor's Office, is also seeking to streamline the client assessment process across OHA and ODHS to address many of the challenges reported by providers. As they complete this work they are also considering the budget implications of potential changes. Under federal rules, Oregon cannot pay for behavioral health services through APD's federal 1915(k) waiver for home and community-based services and must reimburse these services through separate Medicaid funding streams administered by OHA. The joint policy option package introduced by OHA and ODHS for the 2025 session is intended to address these challenges within the authority the state does have.

RECOMMENDATION #5: EXPAND MEDICAL RESPITE PROGRAMS STATEWIDE

The Task Force recommends that the Legislative Assembly direct OHA and provide resources to explore options to develop greater coordination and expansion of medical respite programs statewide for people experiencing homelessness. This may include:

- Partnering with Coordinated Care Organizations (CCOs) and homeless service providers to expand medical respite programs through existing CCO initiatives;
- Coordinating delivery of medical respite care with Medicaid-paid Health Related Social Needs (HRSN) or Health Related Services (HRS) housing benefits;
- Developing options for reimbursement of home health and in-home care services in shelters; and,
- Covering medical respite care as an Oregon Health Plan (OHP) benefit (distinct from other OHP housing benefits), with any necessary federal approvals and, to the extent possible, with matching funds.

Key Findings and Rationale for Recommendation 5

Members identified the need to develop new care options for people who discharge from the hospital to emergency shelters for lack of other community-based care or housing options.

ATI Advisory provided a snapshot of medical respite policies and programs as an alternative model of care to support individuals experiencing homelessness or complex care needs.[44] Medical respite programs provide acute and post-acute care for individuals experiencing homelessness who are too ill or frail to recover on their own from a physical illness or injury, but not sick enough to be in a hospital. Medical respite closes the gaps between hospitals and homeless shelters that lack the capacity and licensing to provide medical support needed for recuperation.

[44] ATI Advisory. "Providing Medicaid Coverage and Reimbursement for Medical Respite in Oregon. July 30, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284900

[date of finalization]

Research shows these programs reduce hospital admissions, emergency department visits, and length of stay while improving individuals' housing status.

Medical respite typically falls into the following categories defined by states and CMS:

- **Short-term post-hospitalization housing.** Short-term housing for individuals who do not have a residence to continue recovery from physical, psychiatric, or substance use conditions. Care typically includes wraparound services and case management and may include ongoing physical and behavioral health services.
- **Recuperative care.** Short-term residential care with ongoing medical care, such as medication monitoring, wound care, monitoring vital signs, supporting nutrition and diet, and other physical and behavioral health services.

In the current delivery system, medical respite is provided on a limited basis that varies by region.[45] When an individual is ready for discharge, hospital planners may refer an individual to a non-profit shelter, with or without recuperative care, if available in the region. In certain instances, short-term housing support may be available, along with wrap-round services including case management between transitions.

ATI Advisory reviewed the funding models currently used by the small number of medical respite care programs in Oregon (see Exhibit 11).[46]

Exhibit 11. Current Funding Models for Medical Respite Programs in Oregon

Funder	Examples
State general fund grants and investments	• Project Turnkey 2.0 grant funding enabled new medical respite beds at non-profit shelters. • ODHS' Office of Resilience and Emergency Management used general fund dollars during COVID to provide housing to those needing safe places to recover following hospitalization.
Coordinated Care Organizations	• Oregon's SHARE Initiative established in HB 4018 (2018) requires a portion of CCO profits to be spent on housing related services—some of which are invested in medical respite facilities.

[45] ATI Advisory. "Providing Medicaid Coverage and Reimbursement for Medical Respite in Oregon. July 30, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284900

[46] ATI Advisory. "Providing Medicaid Coverage and Reimbursement for Medical Respite in Oregon. July 30, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284900

[date of finalization]

Funder	Examples
	• CCOs use flexibility within global budgets to provide health-related services, which may include temporary housing. CO wrap-around services include care navigation and transitions between services.
Other grants, partnerships, and non-profit efforts	• Private philanthropic grants from Bezos Day One Fund, for example, helped Mid-Willamette Valley Community Action expand shelter bed capacity. • Other nonprofit medical respite providers report receiving grants from CCOs, hospitals, and private donors.

Source: ATI Advisory. "Providing Medicaid Coverage and Reimbursement for Medical Respite in Oregon. July 30, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284900

Oregon could expand access to medical respite without first needing to obtain additional federal approvals.[47] Oregon can use existing Medicaid managed care flexibilities and these **pathways to promote medical respite care:**

- **Coordinated Care Organization (CCO) opportunities**, such as 1) using the CCO procurement process to require that new CCO contracts address post-discharge needs for homeless individuals; 2) strengthening requirements in existing CCOs' contracts to include medical respite providers, or 3) strengthening SHARE Initiative guidance that CCO reinvestments should include medical respite care.
- **Provider opportunities.** For example, Federally Qualified Health Centers can operate medical respite programs and receive reimbursement from CCOs (including through alternative payment models for non-traditional services). Other medical respite providers may also form relationships with CCOs to provide care (including by working with CCOs to meet benchmark goals).

ATI noted states may also reimburse medical respite care as a Medicaid-covered service.[48] These approaches have varying requirements for federal approval and offer varying levels of federal matching funds:

- Medicaid State Plan Amendment (such as Minnesota).
- Managed care "In Lieu of Services" (ILOS) (such as Illinois).

[47] Id.

[48] Id.

- Section 1115 Medicaid demonstration waiver (5 states currently, 7 pending).[49]

ATI noted that in the short term, Oregon could use the CCO procurement process to encourage CCOs to expand medical respite services within their existing global budgets. In the longer term, Oregon could develop new medical respite coverage options, financing this coverage through a state plan amendment and state general funds, or pursuing an 1115 waiver to secure federal financial participation in the benefit cost.

Member Considerations

Members discussed the potential for medical respite models to help address hospital discharge challenges in Oregon. Key considerations included:

- These programs serve a small proportion of all potential clients experiencing discharge delays but would address a specific need for one part of the population that is often the most difficult to place in community-based care.
- Using a Section 1115 demonstration waiver to make medical respite a covered benefit under the OHP would maximize consistent access to these services across the state and is a desirable long-term goal.
- If leveraging Section 1115 authority to cover medical respite care, OHA will need to consider existing lifetime limits on Medicaid-paid housing benefits. This could include development of a non-housing benefit structure, or coordination to provide a sequential pathway from respite to housing.
- Given the long timeline to request federal approval of a Section 1115 demonstration waiver, it is important to also explore near term options and use existing resources to provide nursing staff on site at shelters or other similar models.

[49] In 2024, five states operated medical respite programs under an 1115 waiver with another 7 states requesting to do so pending CMS approval. Examples include: 1) California: Up to six months of short-term post-hospital housing, 2) Kentucky: Up to 45 days of recuperative care, and 3) Hawaii: Post-hospital housing for people who are homeless.

Domain 3: Leveraging Coverage and Provider Reimbursements to Improve Access to LTSS

Nationally, long term services and supports (LTSS) are used by a range of individuals, the majority of whom (55%) are older or physically disabled. Other groups include people with developmental disabilities (25%), behavioral health needs (7%), or people who fall in more than one of these groups (13%).[50] Spending on long term care for these populations varies across states and settings.

The Task Force studied how LTSS are covered and paid for in Oregon and whether changes in health plan coverage or provider reimbursements could help address hospital discharge challenges.[51] Broadly:

- **Medicare generally does not pay for long-term care.** Traditional Medicare does reimburse skilled nursing facility care (only after a hospitalization and limited to 100 days) and home health care for individuals who are homebound or need intermittent or part-time services.
- **Medicaid is the primary payer for LTSS**. The federal government requires state Medicaid programs to cover nursing facility care. Coverage of home and community-based services (HCBS) is optional. Nationally, Oregon spends the highest share of its Medicaid LTSS dollars on HCBS (83.3%).[52]
- **Many people pay privately for LTSS or receive unpaid care from family members.** However, there are significant unmet needs for LTSS among people who go without sufficient formal or informal long-term care.

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

[50] ATI Advisory. "Analysis of Benefits, Coverage, and Payment Policy for Post-Acute Care." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284676

[51] Id.

[52] Id.

[date of finalization]

HB 3396 directed the Task Force to study these issues in more detail for certain post-acute care providers. The Task Force gathered additional information on the following entities closely involved in delivering post-acute care:

1. **managed care entities** that provide health plan coverage to Medicaid and Medicare Advantage enrollees in Oregon.
2. **home and community-based care providers** including adult foster homes, residential care and assisted living facilities, and in-home care providers.
3. **institutional and medical care providers** including skilled nursing facilities, home health agencies, and outpatient hemodialysis centers.

The Task Force advanced three recommendations in Domain 3:

6. Engage Coordinated Care Organizations and Dual-Eligible Special Needs Plans
7. Update Payment Methods for Adult Foster Homes
8. Extend the Post-Hospital Extended Care Benefit

These Domain 3 recommendations are further explored in this section with additional background and analysis that informed Task Force discussions.

RECOMMENDATION #6: ENGAGE COORDINATED CARE ORGANIZATIONS AND DUAL-ELIGIBLE SPECIAL NEEDS PLANS

The Task Force recommends the Legislative Assembly direct and provide resources to the Oregon Health Authority (OHA) and the Oregon Department of Human Services (ODHS) to explore options to leverage existing managed care authorities to:

- require Coordinated Care Organizations (CCOs) and Dual-Eligible Special Needs Plans (D-SNPs) to provide more targeted care coordination and case management at the point of hospital discharge;
- strengthen integration between hospital discharge planning and new Health Related Social Needs (HRSN) supports;
- strengthen CCO utilization of new required Traditional Health Worker networks for care transition support; and
- promote access to home modification services and supports that enable people to discharge from hospital to their home.

Key Findings and Rationale for Recommendation 6

Managed Care Entities

The Task Force received an overview from ATI Advisory regarding how the state can partner with managed care entities to promote timely and appropriate hospital discharges.[53] Oregon's managed care landscape includes:

- **Sixteen CCOs** providing Medicaid coverage to approximately 1.2 million Medicaid beneficiaries;
- **Seven D-SNPs** providing Medicare-Medicaid coverage to 170,000 "dual eligible" beneficiaries;
- **Medicaid LTSS** funded directly by ODHS and OHA. CCOs have memoranda of understanding with Area Agencies on Aging to coordinate local delivery of LTSS, but LTSS are otherwise carved out from CCO global budgets.

[53] ATI Advisory. "Analysis of Benefits, Coverage, and Payment Policy for Post-Acute Care." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284676

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

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

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

CCO Procurement

The state is contracted with its current CCOs through December 2026. The upcoming 2025 RFP for new CCO contracts presents an opportunity for Oregon to establish expectations early in the procurement process, as well as evaluate CCOs on the strength of their responses to new requirements. For example, the state could ask during this process how CCOs plan to address transitions of care for people experiencing homelessness or severe behavioral health conditions. If OHA exercises this authority, the agency must consider how it will ensure fair evaluation of all questions and responses across CCOs, and how it will ensure oversight of any new contractual requirements.

CCO Contracts

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

- **Health Related Services.** CCOs have existing discretion to offer Health-Related Services (HRS) such as food support, short-term or temporary housing assistance, etc. Members are often unaware of these benefits.

- **In Lieu Of Services (ILOS).** CCOs are permitted to offer certain preapproved services (such as Community Health Worker or Qualified Mental Health Associate services in alternative settings) when these are medically appropriate substitutes for traditional OHP covered services.
- **Community investments.** CCOs can use community benefit initiatives to support community programs addressing social needs. CCOs can also use their required SHARE program investments to address housing-related services that address hospital discharge challenges.

A new OHP benefit, Health-Related Social Needs (HRSN), will also cover limited housing supports for specific populations beginning in late 2025.[54]

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

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

D-SNP Contracts

Oregon can use its existing authority to influence how D-SNPs provide care to dual eligible individuals. This is a much more streamlined process than modifying CCO contracts. D-SNP contracts are overseen by OHA and are due to CMS for approval in July of each year; states can amend these contracts annually (in some cases, more frequently). OHA could partner with ODHS on D-SNP program design and oversight to improve how people enrolled in D-SNP access LTSS. More robust program design changes can take anywhere from 2-12 months to work with stakeholders on changes to contracts. Medicare Advantage plans allow for supplemental benefits, such as meals, non-medical transportation, and general supports for living (rent or utility assistance) that can help address key barriers to hospital discharge. In Oregon, very few D-SNP enrollees currently have access to supplemental benefits such as non-medical transportation or general supports for living (e.g., rent or utility assistance).

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

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

[54] HRSN benefits will include rent and tenancy services, and home modification and remediation services, for OHP enrollees who meet certain clinical and other eligibility criteria. See Oregon Health Authority, "Oregon's 1115 Medicaid Waiver Update," (September 24, 2024 presentation to the House Interim Committee on Behavioral Health and Healthcare). Available at https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/285587

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

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

Oregon could encourage D-SNPs to engage with the state on supplemental benefits that support successful and streamlined hospital discharges, and to have a designated point of contact for local coordination of benefits, similar to the current requirement that CCOs coordinate with Area Agencies on Aging for LTSS beneficiaries.

Home Modification Supports

The Task Force studied how home modifications are covered by OHP and D-SNP plans for people who need these supports when they discharge from the hospital to their home. Exhibit 12 includes details provided by ATI Advisory and the Oregon Health Authority.

Exhibit 12. Coverage of Home Modification Supports

Payer	Required and Discretionary Covered Services
Medicare Advantage: Dual-Eligible Special Needs Plans (D-SNP)	• May cover home modifications as a supplemental benefit for dual-eligible beneficiaries. This is not required by the federal government and as of 2024, no Oregon D-SNPs offer home modifications as a supplemental benefit. Some states require D-SNPs to offer specific supplemental benefits, such as home modification supports.[55]
Coordinated Care Organizations	• All CCOs provide discretionary housing supports and services through Health-Related Services (HRS), but CMS does not permit OHA to dictate which HRS are covered. • Beginning in late 2024, certain populations (including dual-eligibles and people at risk of homelessness) will be eligible

[55] ATI Advisory strongly cautioned Oregon against prescriptive requirements for D-SNP supplemental benefits, as such requirements in isolation may lead to unintended market outcomes. Instead, best practice is that states engage and collaborate with D-SNPs on supplemental benefit offerings that support state goals.

Payer	Required and Discretionary Covered Services
	for home modifications as a Health-Related Social Needs (HRSN) benefit. • CCOs cover durable medical equipment such as grab bars, hospital beds, etc., that can assist a member in discharging to their home. This does not include significant modifications to a residence.
Oregon Health Plan "open card" fee-for-service coverage	• Enrollees in fee-for-service OHP are not eligible for HRS that could cover home modifications. Those who meet specific criteria are eligible for HRSN. • Enrollees are eligible for coverage of durable medical equipment.
ODHS 1915(k) State Plan Option	• APD and ODDS cover "environmental modifications" that support a client's self-management of activities of daily living (ADL), instrumental ADL, or health-related tasks and reduce the need for care services. Modifications typically cannot exceed $5,000. • Home repairs are allowed if housing issues prevent safe performance of ADL/IADL.
OHA 1915(i) Waiver	• Specifically excludes coverage of home modification supports. • Can include housing supports such as skills coaching and assistance in securing other benefits.

Source: 1) "Task Force Meeting #9 Summary", June 27, 2024. Available at: https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284907. 2) "Summary of home modification provisions by Oregon Health Authority and Oregon Department of Human Services." July 15, 2024. Available at: https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284906

Member Considerations

Members considered these options to leverage managed care authority to address hospital discharge challenges, with consideration that:

- It should be a priority to assist hospital patients in transitioning home when this is possible. Oregon should maximize its options to cover home modifications given the state's limited capacity in institutional and HCBS settings.
- Until the state reaches an adequate housing supply, people who are housing insecure or homeless will continue to discharge to the street or emergency shelters. Wraparound supports are needed as a near-term step to connect people to services for which they are eligible such as Supplemental Nutrition

Assistance Program (SNAP) or Supplemental Security Income (SSI). CCOs could be encouraged or required to help with enrollment in these programs as part of care coordination.

- While CCOs should continue to leverage Health Related Services and other resources to remove barriers to discharge, it is also critical for LTSS caseworkers to participate in CCO care coordination efforts to help CCOs improve discharge timelines.

RECOMMENDATION #7: UPDATE PAYMENT METHODS FOR ADULT FOSTER HOMES

The Task Force recommends that the Legislative Assembly should:

- Increase base rates for Adult Foster Homes (AFHs). ODHS should work with community partners to determine whether changes to assessment processes are necessary to improve transparency and predictability in reimbursements while minimizing reliance on rate exceptions.
- Fund ODHS to pay a higher base rate for Adult Foster Homes while ODHS explores new rate methodologies. Increased rates for AFH should not come at the expense of rate increases for other post-acute care settings.
- Direct ODHS and Oregon Housing and Community Services (OHCS) to study opportunities to offset the cost of creating new adult foster homes and other community-based care settings, with a report back to the Legislative Assembly no later than August 15, 2026. Approaches may include county-level microlending programs or land trusts.

Key Findings and Rationale for Recommendation 7

Home and Community-based Care Rates

House Bill 3396 directed the Task Force to study reimbursements for a range of community-based care providers in its analysis, including:

- adult foster homes (as defined in ORS 443.705).
- residential care and assisted living facilities (as defined in ORS 443.400).
- in-home personal care agencies (as defined in ORS 443.305).

In developing its recommendations to improve access to post-acute care, the Task Force considered the payment models used to develop reimbursements for these providers, the historical and current rates paid, and other factors impacting these providers' ability to accept patients with complex needs. These are explored below.

ODHS contracts with Burns and Associates, a health policy consulting firm, to develop the rates that ODHS' Office of Aging and People with Disabilities (APD) pays for LTSS. Burns and Associates provided the Task Force with an overview of rates and payment methodologies for APD providers, including AFH, residential care

facilities (RCF), and assisted living facilities (ALF).[56] Oregon's current methodology for AFH and RCF is different than the methodology for ALF. All three approaches are described in Exhibit 13 below.

Exhibit 13. Select APD Rate Methodologies, 2024

Provider Type	Rate Methodology
Adult Foster Home (AFH)	• AFHs may care for up to five individuals. Under the state's current methodology, the base rate of $2,029 per month covers a 1:5 staffing ratio. • The base rate may be augmented by up to three 'add-ons' for $369 per month for: 1) full assistance in mobility, eating, or elimination; 2) behavior that poses a risk to the individual or others; and/or 3) medical treatments that require oversight by a licensed healthcare professional. Rate exceptions may be approved to cover additional staff needed. • Special needs contracts are available that pay higher rates to support individuals with specified needs such as brain injury, cognitive/memory care, ventilator dependence, or behavioral needs. Special needs contracts range from $3,665-$23,647 per month.
Assisted Living Facility (ALF)	• ALFs are similar to RCFs but provide care to six or more individuals in fully self-contained living units with individual kitchen and bathroom spaces. • The payment methodology for ALF differs from AFH and RCF. There are five rate tiers based on the level and type of support an individual needs. Rates range from $1,830 to 4,298 per month. • Memory care endorsed facilities receive $5,977 per month.
Residential Care Facility (RCF)	• RCFs are buildings or a complex with living units (shared or individual) that provide care for six or more individuals. • The payment methodology is very similar to AFHs but with slightly higher rates. Under the state's current methodology, the base rate is $2,279 per month and may be augmented by up to three add-ons for $443 per month. • Memory care endorsed facilities receive a monthly rate of $5,977. Rate exceptions may be approved for additional staff.

Source: Pawlowski, S. "Update on Rate and Wage Study." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284677

[56] Pawlowski, S. "Update on Rate and Wage Study." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284677

[date of finalization]

It has been more than 20 years since Oregon conducted a comprehensive review of payment methodologies and rates for APD services. Through a budget note in SB 5506 (2023), the legislative assembly directed ODHS to "conduct a comprehensive rate and wage study across home and community-based service delivery systems." Burns and Associates conducted the rate study in 2024 and determined it is no longer possible to identify what costs (such as wage levels) are assumed to be covered by the current rates the state has collectively bargained.

Burns and Associates reported other **early insights from the rate study**, including:

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

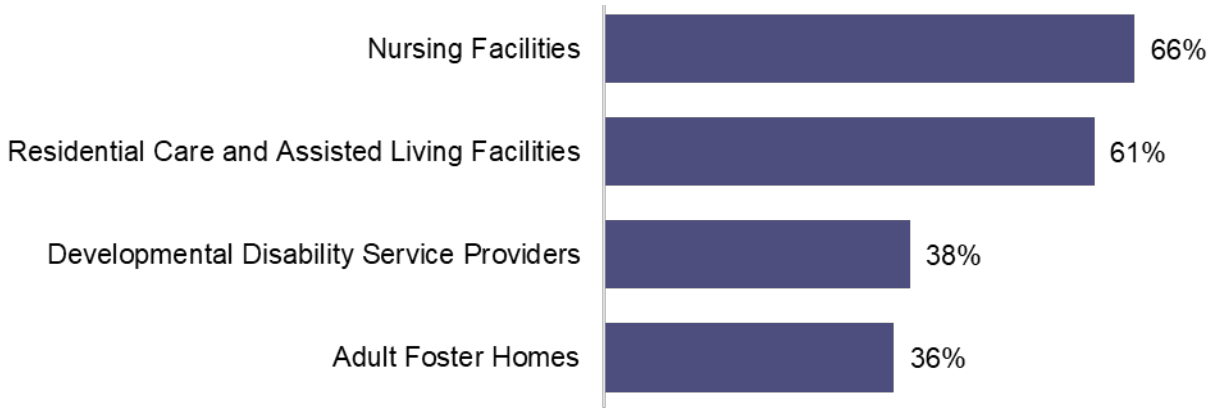
Across APD, all services have received rate increases in Oregon in the past five years.[57] These increases differ across provider types: 36% for AFHs; 61% for ALF/RCFs; 66% for nursing facilities (NF); and 38% for developmental disability service providers (see Exhibit 14). Burns and Associates cautioned that changes in rates over time do not speak to the appropriateness of the rates themselves. Comparing rate increases across provider types requires an assumption that baseline rates for providers were reasonable or appropriate relative to those providers' costs, which may not be accurate.

The preliminary Rate and Wage study report was posted for public comment on October 7th and a final report is to be submitted to the Legislative Assembly by December 1, 2024.

[57] Pawlowski, S. "Update on Rate and Wage Study." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284677

[date of finalization]

Exhibit 14. 5-Year Change in Post-Acute Provider Reimbursements, by Type



Source: Legislative Policy and Research Office

Data: Pawlowski, S. "Update on Rate and Wage Study." June 27, 2024 presentation.
https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284677

Consultant Research

ATI Advisory shared findings from across their analyses related to HCBS provider reimbursements, with a particular focus on adult foster homes.[58] **Key points** included:

- Adult foster homes reported the fewest barriers to accepting individuals with complex needs, including homelessness or housing insecurity. Interviews also consistently revealed that AFHs are most readily willing to accept individuals with complex needs from hospitals.
- However, AFH capacity to accept these clients is limited by workforce shortages and insufficient reimbursements. 63% of AFHs disagreed that payments sufficiently cover care for people with complex needs.

These workforce and rate challenges are further complicated by AFH licensing structures. AFHs are separately licensed to serve three populations and rates vary across these licensure types in 2024 (see Exhibit 15). AFH rates are negotiated through collective bargaining with SEIU 503.

[58] ATI Advisory. "Analysis of Benefits, Coverage, and Payment Policy for Post-Acute Care." June 27, 2024 presentation.
https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284676

Exhibit 15. Foster Home Reimbursements, by License Type, 2024

Foster Home Type	Monthly Average Rate*
APD foster homes for older adults and people with physical disabilities	$2,029-$3,136 per month, on average
Behavioral health foster homes	$2,738
Foster homes for people with intellectual and developmental disabilities	$3,500-$5,500 (as high as $9,000 for exceptional needs contracts)

Source: ATI Advisory. "Analysis of Benefits, Coverage, and Payment Policy for Post-Acute Care." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284676

Note: Each facility also receives a $733 room and board payment.

ATI Advisory reviewed Washington State's acuity-based payment approach for AFHs as an example of how a state can support AFH capacity to treat patients with complex needs.[59] **Highlights of this payment model** include:

- State case managers evaluate clients using an assessment tool to determine the level of care needed. The assessment considers cognitive issues, complex medical conditions, moods and behaviors, and ability to engage in ADL.
- Seventeen unique rate tiers reflect different levels of care needed. Additional daily payment increases are available for expanded community services, specialized behavior support, community integration, HIV/AIDS treatment, and meaningful day services, at all rate tiers.
- Rates are negotiated between Washington State and a union, and range from $3,400 to $6,293 per month in 2024. Washington's legislature fully funded the AFH bargaining agreement in 2023, with a 29% increase in the base payment.[60]

The Task Force also received information from Oregon Housing & Community Services (OHCS) about the Elderly and Disabled bond program established in the late 1990s to create multifamily housing for older adults and people with disabilities.[61] Under this program, OHCS made mortgage loans to private, public, and nonprofit developers for 20- and 30-year loans at below-market interest rates,

[59] ATI Advisory. "Analysis of Benefits, Coverage, and Payment Policy for Post-Acute Care." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284676

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

[61] Correspondence with Tanisha Rosas, Oregon Housing and Community Services. July 11, 2024.

[date of finalization]

backed by the state General Fund. Under this program, OHCS financed the creation of 194 Community Integration Program homes (with capacity for 907 residents) through seven bond sales between 1994 and 2002. Homes were required to meet affordability requirements, and typically served populations at 50% of an area's median income.

Once these loans expire, the mortgage holder is released from the bond obligations and free to sell the property at market rate or convert it for other uses. Most home loans financed under this program have already expired or will do so in the next five years. According to OHCS, many of these homes have struggled to operate financially as they rely on rent collections and receive no other health system support.

Member Considerations

Members considered how changes to reimbursements to home and community-based providers could help address hospital discharge challenges, with consideration for the following:

- **Payment methodology uncertainty for providers.** The payment methodology for HCBS providers, including AFHs, creates substantial uncertainty for providers. Rates are widely acknowledged to be too low, but providers must seek rate exceptions from APD (or OHA) to receive a rate perceived as more appropriate for clients with complex needs. This exception process, which relies on case-by-case negotiations with the agencies, is time consuming and cumbersome for both the state and providers. Members preferred an approach that would offers transparency in the rate tiers and consistency in how rates are applied.
- **Insufficient Rate Relative to Caregiver Demands**. The current methodology awards additional staff support in 15-minute increments. This approach is not viable for HCBS providers who serve five or fewer clients and need to hire workers for partial or full shifts. Union surveys of AFH providers find widespread concerns about insufficiency of rates relative to the demands on caregivers. Other entry-level jobs can offer similar wages with more flexible hours or work-life balance.
- **Provider Payment Parity**. The current approach to separate licenses for AFH types results in providers pursuing IDD licenses due to higher reimbursements, despite greater need for APD and behavioral health foster home providers. Members discussed the need to increase reimbursement for all providers, and for parity across provider types.

- **Barriers to Market Entry**. The cost of real estate in Oregon is also a barrier to new AFH providers entering the market. Local efforts have been made to offset startup costs through approaches such as land trusts, microlending, or small business plan support from county economic development offices. These could be scaled.

RECOMMENDATION #8: EXTEND THE POST-HOSPITAL EXTENDED CARE BENEFIT

The Task Force recommends that the Legislative Assembly provide budgetary authority and funding for OHA to extend the post-hospital extended care benefit from 20 days to 100 days for Oregon Health Plan (OHP) enrollees.

OHA should:

- immediately pursue a state plan amendment or any other necessary approval.
- add this policy change in the 2026 restatement for CCOs and follow the "significant change" process involving presentations to CCOs.
- identify a measurement mechanism to assess whether the extended benefit improves the timeline for discharge to skilled nursing facilities.

Key Findings and Rationale for Recommendation 8

House Bill 3396 directed the Task Force to also study provider capacity and reimbursement issues for certain **medical providers of post-acute care**, including:

- nursing facilities (as defined in ORS 442.015);
- home health agencies (as defined in ORS 442.014); and
- renal dialysis providers.

ATI Advisory completed a supplemental analysis of rates for post-acute providers that were not included in the ODHS rate and wage study.[62] These providers primarily provide post-acute medical care including skilled nursing facilities (SNF), home health agencies (HHA), and dialysis services, for whom Medicare is the primary payer. This analysis sought to understand whether and how payment issues may relate to hospital discharge challenges. Key findings from their analysis include:

- Nursing facilities have largely recovered from pandemic disruption. Service volumes rebounded from 2020-2021 lows, and providers resumed normal

[62] ATI Advisory. "Analysis of Benefits, Coverage, and Payment Policy for Post-Acute Care." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284676

financial operations following federal relief funds during the public health emergency.

- Labor cost inflation continues to outpace Medicare and Medicaid reimbursement increases for many providers. A new federal minimum staffing mandate for nursing homes is also creating substantial uncertainty. Oregon already has some of the highest staffing minimums in the U.S., but this change may still impact many Oregon NFs.
- Between 2017-2022, SNF rates increased across all payers. For HHAs and dialysis centers, Medicare rates were flat or rose slightly, while Medicaid rates declined. Trends were consistent across regions and patient subpopulations.

Overall, it is not clear that reimbursement changes are directly driving discharge challenges to nursing facilities, home health, or dialysis providers. ATI did note reimbursement rates likely have not kept pace with labor cost inflation, which could constrain providers' ability to hire more staff.

Improving Coverage of Nursing Facility Care

Oregon offers two types of Medicaid coverage for nursing facility care:

- **Short-term post-hospital coverage.** OHP medical will pay for up to twenty days of post-hospital extended care (PHEC) in a nursing facility following a 3+ day hospital stay. This PHEC benefit is for OHP enrollees under age 65 who are not dually covered by Medicare. It is paid by a CCO or OHP Fee-for-Service depending on a member's OHP enrollment.
- **Long-term coverage.** ODHS provides long-term coverage of nursing facility care for people who qualify for Medicaid-paid LTSS and need a nursing-facility level of care. This coverage has a separate eligibility determination process from PHEC coverage.

OHP members who use short-term PHEC coverage are intended to discharge from the nursing facility within 20 days or transition to LTSS coverage for continued nursing facility or other long-term care.

Task Force members identified challenges with the PHEC benefit that can contribute to delayed hospital discharges.[63] The 20-day benefit is shorter than the timeline needed to complete an LTSS eligibility determination, which can contribute to a gap in continuous coverage for nursing facility care among OHP enrollees who are

[63] Legislative Policy and Research Network. "Joint Task Force on Hospital Discharge Challenges Meeting #5." January 26, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283794

eligible for LTSS. The 20-day benefit is also insufficient to cover a standard regimen of intravenous antibiotics, a common reason OHP enrollees need post-hospital nursing care.

The Task Force requested Oregon Health Authority provide information on options to extend the PHEC benefit. An OHA actuary provided an analysis of Medicaid claims to understand **current utilization of the PHEC benefit**.[64] Details included:

- Between July 1, 2022, and June 30, 2023, 157 skilled nursing stays were reimbursed under PHEC coverage. These were roughly split between CCO members (70 stays) and members enrolled in OHP fee-for-service (FFS) coverage (89 stays).
- To develop a more inclusive estimate of potential fiscal impact, the analysis also captured 1) 18 swing bed stays and 2) PHEC claims for which there was no identified associated hospital stay (13.7% of claims). The total annual cost of this benefit was $1.6 million, capturing nursing facility charges of $617 per person per day. The analysis does not consider other non-facility Medicaid charges (averaging $245 per person per day for, e.g., prescriptions, primary care visits, ambulance transportation) since the focus is on the PHEC benefit specifically. Under the current PHEC coverage model, patients admitted to nursing facilities discharge gradually between days 1-20, with about half discharging at days 19, 20, or 21.

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

- OHA noted that when the PHEC benefit ended, about 45% of this population transitioned to LTSS coverage. Among those who transitioned immediately (within 1 day) from PHEC coverage to LTSS coverage, most remained in a nursing facility. A smaller number transitioned to in-home care. Extending the PHEC benefit would provide seamless coverage to LTSS for this group. Most of the population transitioned off PHEC and did not move to LTSS.
- OHA also considered how an extension of the PHEC benefit would offset other existing costs to the Medicaid program. For example, a PHEC extension may offset some nursing facility charges that would otherwise be paid under LTSS ($507 per day on average), or LTSS-paid in-home care charges of $38 per day. Current PHEC beneficiaries also experience a 21% rehospitalization

[64] Clark-Shim, W. "PHEC Benefit Extension Costs and Impacts." June 27, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284678

rate, which is relatively high, within 30 days after the PHEC period. OHA anticipates that a PHEC benefit extension would reduce rehospitalizations but did not model these potential savings for this analysis.

- OHA considered that extending the PHEC benefit could result in increased admissions to nursing facilities if coverage gaps are driving NFs to reject admissions of clients without LTSS coverage. However, OHA noted that extending the PHEC benefit does not address member suitability for nursing facility placement. Some patients would be inappropriate for discharge to NFs regardless of the length of PHEC coverage.

OHA estimated the cost of extending the PHEC benefit under two scenarios: flat or increased utilization (see Exhibit 16).

Exhibit 16. Cost of Extending the PHEC Benefit

Scenario 1 – No Change in Utilization	Scenario 2 – Increase in Utilization
If the number of OHP enrollees utilizing PHEC benefits remains stable (n=157), the net annual cost to extend the benefit would be: $0.3 million for 30 days of coverage; $0.8 million for 60 days; or $0.9 million for 100 days. These estimates include the direct increase in facility costs to OHP, minus cost offsets to LTSS.	If the number of OHP enrollees utilizing PHEC benefits increases by 50%, the net annual cost to extend the benefit would be: $1.3 million for 30 days of coverage; $1.9 million for 60 days; or $2.2 million for 100 days.

Source: Clark-Shim, W. "PHEC Benefit Extension Costs and Impacts." June 27, 2024 presentation.
https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284678

OHA shared scenario two is a more reasonable basis for estimating costs, if the Task Force advanced a recommendation to change this benefit. Based on these analyses, OHA concluded there are **potential benefits** if Oregon extends PHEC coverage to 30, 60, or 100 days, including:

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

Costs of this change include the direct cost to OHP medical for the benefit extension as well as costs associated with a potential increase in admissions to nursing facilities. Costs may be partially offset by savings from existing LTSS claims as well as potential additional offsets resulting from reduced hospitalizations.

OHA noted that members may wish to focus on the 60- and 100-day extension scenarios given that the 30-day option is still less than a typical LTSS determination timeline and may not address the PHEC-to-LTSS coverage gap.

Member Considerations

Members considered how changes in the OHP coverage for post-hospital extended care benefit could help address hospital discharge challenges, with consideration for the following:

- There are anecdotal reports that nursing facilities deny referrals of Medicaid patients because PHEC coverage is too short or LTSS eligibility after 20 days is uncertain.
- The PHEC benefit is used by a relatively small number of people who are experiencing long hospital stays and improving this coverage would come at a modest cost but could yield significant improvements in hospital capacity. Reducing a delayed discharge by twenty days could translate to an additional four people being treated, assuming an average 5-day stay.
- There is preliminary evidence that these improvements would be realized. PacificSource CCO voluntarily offers a 20-day extension of the PHEC benefit across its CCO regions. This change resulted in an increase in nursing facilities accepting Medicaid referrals.
- One risk is that if the PHEC benefit is extended, NFs may admit a client under PHEC coverage but still wait too long to initiate the eligibility determination process for LTSS. Facilities may need to be encouraged to still begin the process as early as possible.

Domain 4: Supporting the Post-Acute Care Workforce

Both nationally and in Oregon, the post-acute care sector needs more workers to serve an aging population with increasingly complex care needs. HB 3396 directed the Task Force to consider how workforce challenges faced by post-acute care settings impact hospital discharge delays. ATI Advisory presented an overview of trends in the post-acute care workforce, identifying key factors contributing to shortages:

- **Growing population of older adults.** The population 85 and older is projected to grow the fastest by 2035 relative to other groups.[65] At the same time, care needs have grown more complex, with 93% of Medicare beneficiaries discharged to skilled nursing facilities being frail, 52% facing serious mental illness, and 19% facing substance use disorder.[66]
- **Insufficient pipeline of new workers** to meet the growing demand. Nationally, from 2019 to 2022, the number of licensed practical nurses (LPNs/LVNs) decreased by 11%.[67] During the same period, the number of nursing assistants employed in nursing homes decreased by 21%.[68]
- **Labor costs rising faster than reimbursement rates**, making it difficult to attract and retain staff. In 2022, reimbursement for skilled nursing facilities and home health agencies grew 2.4%, while the annual increase in total compensation for all workers in nursing facilities was 6.4%.

Additionally, federal regulations, including new minimum staffing standards for long-term care facilities, will further pressure service providers.

The Task Force advanced one recommendation in Domain 4:

9. Leverage Existing Initiatives to Develop the Post-Acute Workforce Pipeline

This Domain 4 recommendations is further explored in this section with additional background and analysis that informed Task Force discussions.

[65] ATI Advisory. "National Trends Shaping the Post-Acute and Long-Term Care Workforce." March 28, 2024 presentation, at slide 9. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283796.

[66] *Id* at 10.

[67] *Id* at 6.

[68] *Id* at 11.

[date of finalization]

RECOMMENDATION #9: LEVERAGE EXISTING INITIATIVES TO DEVELOP THE POST-ACUTE WORKFORCE PIPELINE

The Task Force recommends that State workforce initiatives—Future Ready Oregon and the Oregon Health Policy Board workforce committee—should develop comprehensive policies to support health care professionals. Specific workforce concepts that will also address hospital discharge challenges include:

- **Career Pathways**. Develop pathways for direct care workers to become (CNAs), and for CNAs to become registered nurses (RNs). Trainings should be portable and stackable across employers. Advanced specializations in hospital care transitions and behavioral health administered by MHACBO could offer pathways to career advancement. Consider additional support for registered apprenticeships for CNAs and LPNs consistent with other initiatives.
- **Nursing Student Clinical Placements**. Expand coordination of nursing student clinical placements and monitor denial of placements over time. The Legislative Assembly should clarify that it is not a conflict of interest for nurses employed at Oregon State Hospital to serve as faculty and preceptors.
- **Student Loan Forgiveness**. Consistent with initiatives across sectors, offer nursing student loan forgiveness or repayment for defined periods of service in post-acute care or as nurse faculty.
- **Nurse Faculty Salaries**. Within public higher education institutions, benchmark nurse faculty salaries to local industry rates.
- **Background Checks**. Within the ODHS-OHA Background Check Unit, monitor processing times following the transition to Rap Back. If needed, the Legislative Assembly should increase BCU capacity to address processing times for pre-employment screening for direct care workers.

Key Findings and Rationale for Recommendation 9

Oregon Workforce Perspectives

The Task Force sought to understand challenges facing Oregon's post-acute professionals, including those not required to be licensed or certified.[69] For all classifications of post-acute nurses, the Task Force explored strategies to reduce barriers to training, education, licensure, and certification.

ATI Advisory interviews with post-acute care providers and labor groups underscored critical gaps in training, wages, and other supports that the post-acute care workforce needs to care for medically and socially complex individuals. Most post-acute care providers feel at-capacity based on their current staff levels. Workers shared that wages and regular hours often do not generate sufficient income, and that many rely on overtime hours to close the gap, which expedites burnout and workforce turnover.[70] Despite this, most post-acute care workers want to stay in their profession.

Advancement for Direct Care Workers and CNAs

In Oregon, approximately 45,000 direct care workers support older adults and people with disabilities across settings. The median hourly wage is $16.86 for personal care and home health aides, and $19.88 for certified nursing assistants (CNA). This workforce is expected to continue to grow at higher rates, with Oregon needing to fill 65,000 jobs by 2030.[71] Advanced roles for these workers can offer a pathway to promotion and higher wages while equipping workers with skills to deliver more complex care.

Public Health International (PHI) presented the Task Force with examples of **advanced roles for direct care workers**, including higher levels of responsibility and compensation.

---

[69]Legislative Policy and Research Office, "Scoping Conversation" January 28, 2024 presentation, at 16. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/279814

[70] *Id.* at 7-8 (providing additional context about part time v. full time employment, racial and ethnic diversity, etc).

[71] Scales, K. "Direct Care Work Force: Key Facts and Trends," March 28, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283791

[date of finalization]

- Direct care workers can serve as peer mentors, assistant trainers, condition-specific specialists, senior aides, transition aides, health coaches, and family coaches or educators.
- A pilot project in New York integrated CNAs with interdisciplinary care teams, resulting in 8% fewer emergency room visits for patients.
- Tennessee's QuiLTSS is an example of a program offering stackable trainings that count toward advanced roles for direct care workers.

Other models are tailored specifically to **advanced roles for CNAs.**

- Specialized CNA training can include areas such as dementia, behavioral health, or end of life care. CNA career pathway programs include models with and without apprenticeships.

Apprenticeship programs are industry-led, paid jobs. Registered apprenticeships allow for credentials and standards that can be transferrable across employers. States can support registered apprenticeships by simplifying grant applications, creating user-friendly portals for submission and tracking, offering technical assistance to employers, and strengthening relationships with industry intermediaries to support administrative aspects of partnerships.

Oregon's RISE Partnership[72] is a labor management trust/partnership between union members and employers. RISE's CareWorks program is a yearlong registered apprenticeship that provides classroom instruction, stipend, preparation for the state exam, and job placement for direct care workers. It trained 87 apprentices in 2023 and may expand with additional funding and partnership from employers.

Nursing Pipeline Barriers

According to the Oregon Longitudinal Data Collaborative (OLDC), Oregon has fewer registered nurses, licensed practical nurses, and CNAs than the national median.[73] Among states, Oregon produces the third fewest nursing graduates per capita among states, and the fewest from its public institutions.[74] Nursing education program capacity is constrained by two factors:

---

[72] Rudiger, B. "RISE Partnership," presentation March 28, 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283790.

[73]Helligso, J. "Postsecondary Healthcare Education Shortage in Oregon," presentation March 28, 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283797.

[74] *Id.* at 12 (not accounting for nurses graduating from private institutions or for Oregon-based students who graduate from programs administered in other states).

[date of finalization]

- **Salaries for nursing faculty**.[75] The mean salary for registered nurses employed in clinical roles is more than the mean salary for nursing faculty. OLDC identified this as the key factor driving the faculty shortage in nursing education programs.
- **Clinical placement limitations**. Nursing programs require clinical rotations before students complete their training. OLDC reports that nursing programs' requests to place students for clinical rotations are frequently denied, especially in rural settings.[76]

Overall, Oregon's public nursing programs accept the lowest rate of qualified nursing applicants among states. Strategies to address these issues include:

- Forming a workgroup on salary disparity for nursing faculty, with a statewide lens and including key institutions.
- Establishing a statewide clinical placement system to reduce competition between programs and locating students in areas of higher need.

Background Checks

Task Force members reported that pre-employment background checks create barriers for prospective post-acute care workers. A "background check" is a review of different kinds of information, including:

- information provided by applicants,
- criminal history reports, and
- verification of employment, training, or good standing by a professional board or agency.[77]

In Oregon, state agencies and professional licensing boards are required to check criminal histories through the Oregon State Police (OSP), either by asking OSP to review records, or directly accessing OSP systems.[78] The Oregon Health Authority (OHA) and Oregon Department of Human Services (ODHS) have a shared office, the

[75] *Id.* at 34.

[76] *Id.* at 39.

[77] Legislative Policy and Research Office, "Memorandum: Criminal Records Checks for Health Care Professionals," March 18, 2024. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283793

[78] *Id.*

Background Check Unit (BCU), that reviews background check information. Private employers may have their own systems and processes for background checks.

Processing times for background checks vary across boards and agencies, depending on 1) whether fingerprints are collected, 2) OSP's response time, and 3) the board or agency's review of background information, which may include employment history and other information in addition to criminal history.[79] Delays to processing times may occur when a criminal history check identifies records that require further investigation or a response from the applicant. When an individual has a positive flag or self-reports criminal history, the investigation process also varies by board. The Oregon State Board of Nursing recently reported decreased processing times.[80]

Background checks can be processed more quickly through strategies such as

- increasing staffing to process applications,
- upgrading online platforms for record submission,
- granting provisional licenses once fingerprint collection is scheduled, and
- reducing barriers to health care employment for people with positive flags in their criminal histories.

HB 4122, enacted in 2024, directs Oregon agencies to make rules to participate in the federal "rap back" program for real-time information-sharing between state and federal agencies using fingerprints.[81] Future rulemaking and implementation of HB 4122 may allow for process improvements to reduce processing times.

State Workforce Initiatives

Policymakers and stakeholders are working to address workforce barriers and shortages across several ongoing initiatives:

- **Future Ready Oregon (FRO)**. Established by SB 1545 (2022), FRO is intended to marshal economic development and workforce strategies across sectors using grantmaking and strategic initiatives. This includes funding to bring priority populations into health care professions such as nursing, behavioral health, and traditional health care workers.[82]

---

[79] *Id.* at 9.

[80] *Id.*

[81] *Id.* at 10.

[82] DeMars, Chris. "Workforce Strategies & Initiatives." March 28, 2024 presentation. https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/283818

- The **Health Care Work Force Committee** of the Oregon Health Policy Board coordinates statewide efforts to recruit and educate health care professionals and to retain a quality workforce. The Committee spent 2023 drafting a strategic framework based on Oregon's Health Care Workforce Needs Assessment.[83]
- **Clinical placements and apprenticeships**. In addition to establishing the Task Force, HB 3396 created investments in clinical placements and apprenticeships.

Member Considerations

The Task Force noted the critical role of both licensed and direct care workers in discussions across every domain and prospective solution the group considered. Potential strategies raised and discussed by members to strengthen the post-acute workforce included:

- **Increasing the minimum wage** for specific groups such as direct care workers, (e.g., New York[84]) or requiring wage passthroughs when Medicaid rates paid to providers increase (e.g. Minnesota[85]).
- **Direct care and CNA advancement**. Additional partnerships or funding through community colleges could support educational advancement for direct care workers into registered nurse or other roles. Apprenticeship options are useful but should be designed to enable participants to pursue further education to grow and advance into different roles after the apprenticeship.
- **Training and/or certification for workers to support patients with behavioral health needs** (including through the Mental Health & Addiction Certification Board of Oregon (MHACBO)). [86] Training workers who already provide care in settings like SNFs to help meet behavioral health needs could better support individuals with complex needs. A concern with this approach

[83] Li, T. et al. "Oregon's Health Care Workforce Needs Assessment," February 2023. https://www.oregon.gov/oha/HPA/HP-HCW/Meeting%20Documents/5.-2023-Health-Care-Workforce-Needs-Assessment-Report-January-2023.pdf

[84] National Governor's Association, "Addressing Wages of the Direct Care Workforce Through Medicaid Policies," November 2022. https://www.nga.org/wp-content/uploads/2022/11/DirectCareWorkforcePaper_Nov2022.pdf

[85] Minnesota Department of Human Services, "Personal Care Assistance Services," February 2011. https://www.leg.mn.gov/docs/2011/mandated/110487.pdf

[86] Legislative Policy and Research Office, *supra* note 75, at 20.

is the regulatory risk and burden on facilities that serve increasingly complex individuals.

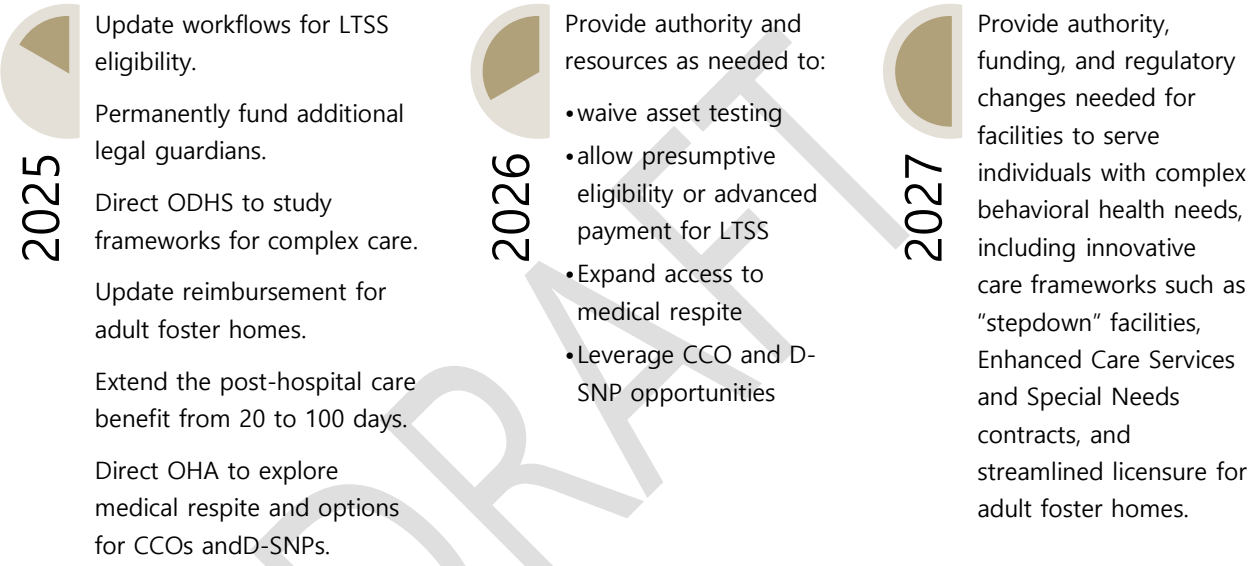
- **Addressing the pipeline for nursing students**, including by increasing salaries for nursing faculty, offering loan forgiveness to faculty and nurses in post-acute settings, and removing barriers to clinical placements.
- **Improving background check processing times**, including through implementation of "rap back."

In discussions across Task Force meetings, members emphasized the importance of addressing health care workforce recommendations holistically to achieve consistent strategies across sectors. In contrast with other areas where the Task Force recommended direct action by the legislative assembly on specific proposals, the group determined that these strategies to bolster the post-acute workforce should ideally be part of the state's existing comprehensive health care workforce initiatives. While no less urgent than other areas for recommended action, these steps should be taken in alignment with other ongoing efforts to develop the health care workforce.

Recommended Next Steps

This report outlines a series of recommendations by the Joint Task Force on Hospital Discharge Challenges to the Legislative Assembly, the Oregon Department of Human Services (ODHS), the Oregon Health Authority (OHA), and key partners including hospitals and long-term care providers. The Task Force recommendations include guidance to the Legislative Assembly to give precise, time-bound direction to ODHS and OHA. In turn, the agencies require funding and authority (see Exhibit 17).

Exhibit 17. Legislative Actions in 2025-27 Legislative Sessions

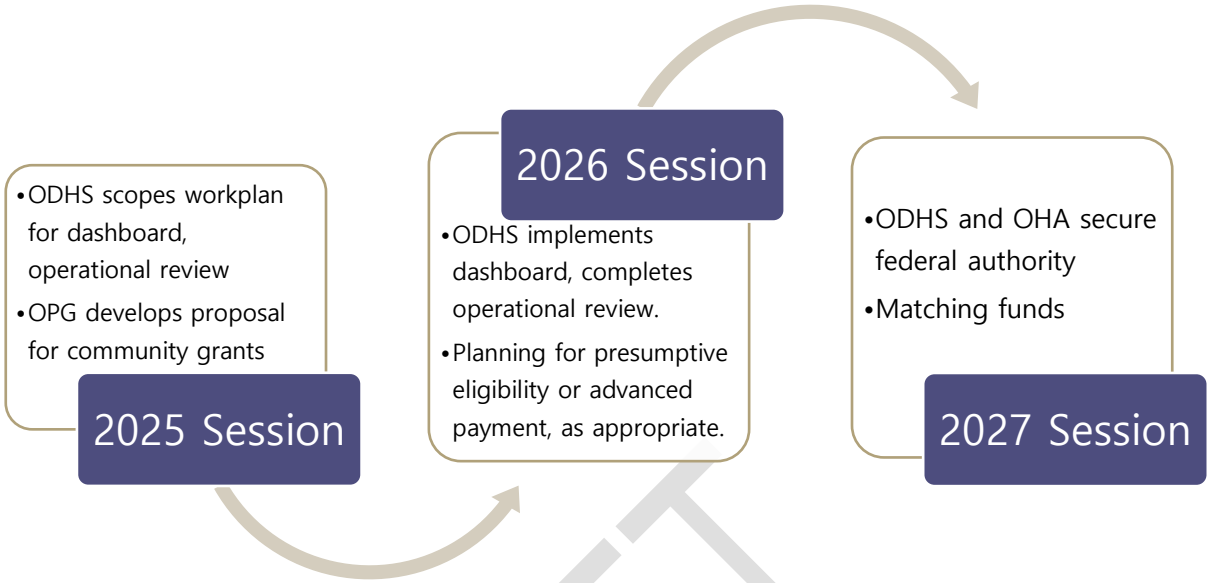


Source: Legislative Policy & Research Office

The Task Force recommends legislative action beginning in the 2025 session to address immediate issues with eligibility determinations for LTSS. LTSS eligibility policy changes requiring additional agency authority or resources should be presented to the legislature in advance of the 2026 session. The agencies should present plans to the Legislative Assembly before the 2027 session to improve the regulatory framework for facilities that serve people with complex care needs.

[date of finalization]

Exhibit 18. Agency Actions in Advance of Legislative Sessions



Source: Legislative Policy and Research Office

State agencies will have a key role in implementing changes and completing additional work in the interims between legislative sessions. Agency work should begin immediately to assess LTSS eligibility processes. In advance of future sessions, ODHS and OHA should present the Legislative Assembly with comprehensive plans to implement presumptive eligibility or advanced payments for LTSS, as appropriate, and to improve the regulatory frameworks for post-acute care facilities.

The Legislative Assembly and state agencies will need to work together to create an effective care continuum. The Task Force recommends actions that include near-term strategies (to be addressed by the end of the 2025 Session), intermediate-term strategies (before the 2027 Session), and long-term strategies (including the 2027 Session and beyond). Below is a step-by-step breakdown of actions to be taken at different stages by agencies and by the Legislative Assembly.

Near-Term Strategies (through the 2025 Legislative Session)

Agency action should begin immediately (and/or continue, as appropriate) to address:

- Data sources, authority, and resources needed to create a dashboard to track LTSS eligibility completion times and to complete an operational review of the agencies' LTSS eligibility processes.
- Evaluation of authority and resources needed to support the expansion of Oregon's Enhanced Care Services and Specific Needs Contracts.
- Evaluation of resources needed to study expansion of medical respite and other options to leverage managed care authorities.

Legislative action in the 2025 session should address:

- Funding and direction for ODHS to create a dashboard to track LTSS eligibility, to conduct an operational review to streamline LTSS assessments, and to develop a time-bound plan to implement improvements.
- Funding and authority for ODHS to study innovative care frameworks, including regulatory changes needed to support patients with complex care and behavioral health needs, including through Enhanced Care Services and Special Needs Contracts; recommendations to promote technical assistance in lieu of civil monetary penalties; analysis of licensure requirements for adult foster homes; and opportunities to create new adult foster homes, including through use of land trusts.
- Improved methodology and increased rates for adult foster homes (through the Joint Ways and Means rate-setting process).
- Funding to extend the Oregon Health Plan post-hospital care benefit from 20 to 100 days for OHP enrollees.

- Continuous funding for five positions in the Office of the Public Guardian (OPG) established in 2024.

Intermediate-Term Strategies (before the 2027 Legislative Session)

Agency action after the 2025 session should include:

- Implementation of the dashboard to track LTSS assessment and strategies to streamline LTSS eligibility screening, including redesign of workflows and staff assignments.
- Analyses of regulatory changes needed for "step down" facilities and other innovative care options for patients with complex behavioral health needs; recommendations for alternatives to civil monetary penalties; analyses of licensure requirements and strategies to create new adult foster homes and other community-based care facilities.

Legislative Action in the 2026 session should include providing any statutory authority or funding necessary for OHA and ODHS to advance presumptive eligibility, advance payment, and asset testing concepts.

Long-Term Strategies (2027 Session and Beyond)

Agency action should include**:**

- Negotiating and securing federal approval and matching funds as needed for implementation of presumptive eligibility, medical respite, and other concepts to promote timely discharge.

Legislative action (2027 session) should include:

- Providing agency direction, authority, and funding needed for facilities to serve individuals with complex behavioral health needs, including regulatory changes; pursuit of other innovative care frameworks such as "stepdown" facilities, Enhanced Care Services and Special Needs contracts; and streamlined licensure for adult foster homes.

Summary

This sequence of actions aims to address the complex challenges faced by Oregonians who are discharging from the hospital with post-acute care needs. Immediate actions target improved speed and efficiency for LTSS eligibility determinations and greater access to legal guardians and medical respite programs. Intermediate and long-term actions to waive asset testing and to expand medical respite and facility options to serve people with complex care needs will require sustained agency engagement, and in some cases, may require federal Medicaid waivers. Ongoing collaboration between the state, providers and community partners will be critical to operational success. By implementing these recommendations over the next several years, Oregon may reduce discharge delays and improve care outcomes for vulnerable populations.

Appendix 1: Needs Assessment

[to be added prior to submission]

[date of finalization]

Appendix 2: Policy Concept Tracker

[to be added prior to submission]

[date of finalization]

Appendix 3. Task Force Workplan and Meetings

[to be added prior to submission]

[date of finalization]