

**Health Services
Office of Medical Assistance Programs**

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OMAP Program and Policy Section

Authorized Signature

Number: OMAP-IM-04-082

Issue Date: 08/13/04

Topic: Medical Benefits

Subject: Letter to Hospital Discharge Planners Regarding Post-Hospital Extended Care Benefit

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Children, Adults and Families | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers | <input checked="" type="checkbox"/> Other (please specify): DHS staff and others identified on the SPD, CAF, OHMAS and OMAP transmittal lists |

Message: OMAP is sending the attached letter to hospitals to clarify policy regarding the post-hospital extended care benefit. A copy of the SPD rule and a Q & A document to assist hospital discharge planners in understanding this benefit is included with the letter. SPD issued Policy Transmittal SPD-PT-04-032 on 7/27/04 regarding this benefit.

If you have any questions about this information, contact:

Contact(s):	OMAP Provider Services		
Phone:	1-800-336-6016	Fax:	
E-mail:			



Oregon

Theodore R. Kulongoski, Governor

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August 13, 2004

To: Hospital Discharge Planners

From: Joan M. Kapowich, Manager *Joan M. Kapowich*
OMAP Program and Policy Section

Re: Post-Hospital Extended Care Benefit

Effective: August 1, 2004



This memo provides important information about the Oregon Health Plan (OHP) post-hospital extended care benefit. Seniors and People with Disabilities (SPD) recently issued a temporary rule that clarifies this benefit. This rule is effective August 1, 2004. Attached you will find a copy of the rule and a Q&A document that should answer many of the questions you may have about the benefit. The Q&A document was developed for Department of Human Services (DHS) staff but contains information that you should find helpful. Please disregard the instructions about entering data into the DHS information system.

Managed care plans will authorize and pay for the post-hospital extended care benefit for OHP members enrolled in their plan. SPD Pre-Admission Screening will authorize the benefit for OHP fee-for-service (open card) members.

Thank you for your cooperation with these changes. If you have any questions regarding this benefit, please contact OMAP Provider Services at 1-800-336-6016.

Attachments (2)

411-070-0032 (Temporary Effective 08/01/2004)

Post Hospital Extended Care Benefit

- (1) The Post Hospital Extended Care Benefit (OAR 410-120-1210(3) (a)(G)) is an Oregon Health Plan benefit that consists of a stay of up to twenty days in a nursing facility to allow discharge from hospitals.
- (2) This benefit must be prior authorized by Pre-Admission Screening for clients not enrolled in managed care.
- (3) To be eligible for the Post Hospital Extended Care Benefit, the client must meet all of the following:
 - (a) Be receiving Oregon Health Plan Plus or Standard, Fee-for-Service benefits;
 - (b) Not be Medicare eligible;
 - (c) Have a medically-necessary, qualifying hospital stay consisting of:
 - (A) An OMAP-paid admission to an acute-care hospital bed, not including a hold bed, observation bed or emergency room bed;
 - (B) The stay must consist of three or more consecutive days, not counting the day of discharge;
 - (c) Transfer to a nursing facility within 30 days of discharge from the hospital;
 - (d) Needs skilled nursing or rehabilitation services for hospitalized condition, meeting Medicare skilled criteria;
 - (e) These skilled services are needed on a daily basis;
 - (f) The daily services can be provided only in a nursing facility, meaning:
 - (A) The client would be at risk of further injury from falls, dehydration or nutrition because of insufficient supervision or assistance at home; or

- (B) The client's condition would require daily transportation to hospital or rehabilitation facility by ambulance; or
 - (C) It is too far to travel to provide daily nursing or rehabilitation services in the client's home.
- (4) The client may qualify for another twenty day Post-Hospital Extended Care Benefit only if the client has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in OAR 411-070-0032 (3).
- (5) Clients eligible for the twenty day Post-Hospital Extended Care Benefit are not eligible for long term care nursing facility or Home and Community Based waiver services unless the client meets the eligibility criteria in OAR 411-015-0100 or OAR 411-320-0010(21, 22, or 23)

Statutory Authority: ORS 409, 410.070, & 414.065

Statutory Implemented: 410.070 & 414.065

Post Hospital Extended Care Benefit (OHP – 20 day)

1. **Is there an OAR describing this benefit?** As of August 1, 2004, administrative rules are found in OAR 411-070-0032(Nursing Facility Medicaid rules), OAR 410-120-1210(3)(a)(G) (Office of Medical Assistance Program [OMAP] General rules), and OAR 410-141-0160(4) (Oregon Health Plan [OHP] Administrative rules – OHP Managed Care rules).
2. **What is the benefit?** This is a nursing facility benefit of a maximum of 20 days following a qualifying acute hospital stay.
3. **How is this benefit different from other SPD-paid nursing facility (NF) stays?** People utilizing this benefit do not need to meet the eligibility criteria for Long Term Care in OAR 411-015-0100 and do not need to meet the Service Priority levels. This benefit is time limited and clients are not eligible for Home and Community Based waiver services (unless they also meet the LTC eligibility criteria).
4. **Who is eligible?** Individuals who meet **all** of the following criteria:
 - receiving Oregon Health Plan Plus or Standard benefits;
 - are **not** Medicare eligible;
 - have a qualifying hospital stay of three or more consecutive days, not counting the day of discharge. The hospital stay must be in an OMAP-paid hospital bed (not including a hold, observation or emergency room bed or a non–acute stay in a psychiatric hospital);
 - admission to a nursing facility within 30 days from their hospital discharge date;
 - need skilled nursing or rehabilitation services for the condition for which they were being treated in the hospital; and
 - need skilled services (which must meet Medicare skilled criteria) which can only be provided in a nursing facility and are required on a daily basis. The nursing facility itself is not required to be certified as Medicare skilled.
5. **How does a client access this benefit?** For those receiving OHP Fee-For-Service benefits (open card), the PAS screener must authorize the

benefit. If the client is in a Fully Capitated Health Plan (FCHP), the stay must be authorized by the managed care plan.

6. **What is the role of the SPD/AAA office?** For those OHP Plus and Standard, Fee-For-Service members who are eligible:
- The PAS screener authorizes the benefit. The PAS screener does not need to complete a full assessment, unless the person maybe eligible for and requesting Long Term Care.
 - The local office opens a Long Term Care file in ELGF with the SSH payment code. Neither an ACCESS nor CAPS file needs to be completed unless the client is also Long Term Care eligible. However, the local office may open an ACCESS or CAPS file in anticipation of a Long Term Care need.
 - The local office enters a service start date and a service end date, not to exceed 20 days from the date of the NF admission. Remember that NFs are not paid for the date of discharge, unless that date of admission is the same as the date of discharge (OAR 411-070-0050). Therefore, entering 20 days will allow payment for 20 days, even though the person may be discharged from the NF on the 21st day.

If the client is in a FCHP, the stay must be authorized by the managed care plan. The local office does not need to open a long term care payment file for the 20 day benefit. If the client continues to require NF level of care once the Post-hospital benefit is exhausted, a PAS screen needs to be completed to determine if the client qualifies for Long Term Care. It may then be appropriate to open a long term care file.

7. **What about OHP copayments, financial liability, and income standards?** This is a medical benefit, not a long term care benefit. The client does not incur any financial liability for this benefit and the income standards are the current income standards for the qualifying program (as if they are not in the hospital or NF).

The Standard population no longer has copays, in response to the recent lawsuit.

8. **OHP Standard is currently closed and if a Standard client does not complete the re-application by the deadline or stay current on their premiums, they lose eligibility. What happens if they are in the nursing facility when these become due?** The Standard client should understand that meeting the deadlines is extremely important to maintain medical coverage. If staff are aware that any of the

deadlines occur during the time of the NF stay, it would be helpful if they contact any known family or notify the NF of the need for action, but it does remain the responsibility of the client. If the NF asks, providers are not allowed to sponsor the premium of a specific client. It is possible that a client may qualify for an ADA accommodation if a disqualification occurs because of the client's disability.

9. **How is this benefit different than Complex Medical Add-On?** Complex Medical Add-On is a supplemental payment for people in Long Term Care. Post-hospital and Complex Medical Add-On do not have the same criteria or eligibility requirements, but are currently paid at the same rate.
10. **Can a person who is eligible for the Post-hospital benefit access waiver services?** No, unless the person also meets the eligibility criteria for Long Term Care.
11. **Can a person who is eligible for Long Term Care receive the Post-hospital benefit?** Yes, if he/she meets both the eligibility criteria for the Post-hospital benefit and the criteria for Long Term Care. The first 20 days, for those in Fee-For-Service (open card), are to be entered by the local office on the long term care payment file SSH). Then beginning on the 21st day, the local office would adjust the long term care payment file to reflect the basic nursing home rate (SS). If on the 21st day, the person qualifies for the Complex Medical Add-On, the NF should request authorization from the SPD central office, in order to receive the Complex Medical Add-On rate.
12. **Can a FCHP waive the hospital stay?** Yes, FCHPs are allowed to provide services above and beyond their requirements. That flexibility is not allowable for those in fee-for-service.
13. **Can the PAS screener waive the hospital stay?** No, it is not possible to make exceptions to this rule without changing the benefit for everyone.
14. **If a FCHP authorizes a stay, can they subsequently deny payment with a retro-review of the 3-day stay requirement?** No, if they authorize the stay, they have committed to the payment. If the facility has been denied payment, they need to first work with the FCHP to resolve the issue. The facility should always retain the name of the person at the FCHP who authorized the visit, in order to resolve this quickly. Once those avenues are exhausted, the appropriate PHP (Pre-paid Health Plan) coordinator at OMAP is a resource for resolution.

- 15. Can a FCHP authorize less than 20 days?** Yes, the benefit is only for the length of time that is medically appropriate. If the member needs less than 20 days, the FCHP may authorize less. If there is disagreement over the length of medical need, routine grievance/appeal procedures should be followed.
- 16. Can a PAS screener authorize less than 20 days?** Yes, the benefit should only be authorized for the length of time that is medically appropriate. However, it is not anticipated that screener will have sufficient time to closely monitor whether the person will need less than 20 days. If a client uses less than the 20 days, the payment file (ELGF) should be adjusted to accurately reflect the number of days the benefit was used.
- 17. Is the 20 days a lifetime benefit or available with each qualifying hospital stay?** Each qualifying hospital stay may include a post-hospital skilled benefit if the client has been out of the hospital and not receiving skilled care in the NF for 60 consecutive days since the last qualifying hospital stay. The 20 days is not a lifetime maximum.
- 18. What happens if the person is not ready for rehabilitation immediately after the hospitalization?** The stay must start within 30 days of the qualifying hospitalization discharge, however there can be a break between hospital discharge and admission to the nursing facility, not to exceed 30 days.
- 19. What happens if the person starts their 20-day stay but wants/needs to go home during the middle of the 20 days?** If the person needs to interrupt their stay and if they return to the nursing facility within 14 days of NF discharge, they may complete the remainder of the 20-day allowance. The local office will need to adjust the client's long term care payment file to accurately reflect the client's dates of stay.
- 20. What happens when a person who doesn't meet criteria for Long Term Care isn't ready for discharge at the 20 days?** If a client appears to possibly meet eligibility criteria for presumptive disability, referral should be made as quickly as possible, prior to the 20th day. The request should indicate that the determination needs to be expedited. It may be appropriate to call the Presumptive Medical Disability Determination Team (PMDDT) to ensure a timely response. For individuals who need more than the 20 days, do not qualify for LTC, and do not meet the criteria for presumptive

disability eligibility, the state will not pay for the nursing facility more than the 20 days.

21. **Does the individual have hearings rights for involuntary transfer if the facility issues an eviction notice?** Yes, the individual has those hearing rights. However, nonpayment is a reason for eviction. It is possible that the facility will incur 60 to 90 days of non-payment from the state before this process is completed. Hence, some facilities may be reluctant to admit these clients.
22. **OHP Standard benefit package just changed 8/1/04 and no longer covers therapies. What happens if therapy is the reason for the NF admission?** A few nursing facilities provide therapies in their all-inclusive rate. (Contact the prospective facility for this information.) However, at the direction of the Legislature and with the approval of CMS, OHP Standard benefit package no longer includes payment for therapies (among other benefits) and OMAP will not authorize or pay for therapies for Standard clients. If the need for therapy is the qualifying criteria for skilled care, the client still qualifies for the Post-Hospital benefit, even if OHP will not pay for their therapy. It would be appropriate for the PAS screener to authorize the NF stay if the client will benefit from other services provided by the facility, such as assistance with ADLs, IVs, complicated pain control, dressing changes, diabetic control, or habilitation usually provided by NF staff. It is possible the client could decide to pay for the therapies him or herself. However, it is more likely the client will forgo therapy. It is anticipated that nursing facilities may refuse to admit Standard clients who need therapy because of licensing concerns that they are not providing all needed treatments.

23. Is there a cheat sheet about eligibility for different services? The following table may help. Assume that all clients meet the other specific criteria for the service.

Client	Service			
	OHP Therapy	Post-Hosp.	LTC & Waiver	Complex Med. Add-On
OHP Standard	No	Yes	No	No
OHP Plus not meeting LTC criteria	Yes	Yes	No	No
OHP Plus & LTC eligible	Yes	Yes	Yes	Yes