Hospital Decompression Discharge Program

The goal of the Hospital Decompression Discharge Program is to assist certain individuals who are ready for discharge and are not currently eligible for LTSS.

Until further notice, this program is for individuals who need to discharge from the hospital and have one of the following:

- Medicare only benefits and are currently not applying for LTSS
    - The determination and case management will be managed by CO.
- Medicare only benefits and are applying for LTSS
    - The determination and case management will be managed by the LO. Although this program is an option for this category, LOs should proceed with the traditional intake process if a final determination can be made quickly.
- Medicaid benefits but has not been determined eligible for LTSS (i.e. not completed the financial/service process)
    - The determination and case management will be managed by the LO.

*This program is general fund only. Individuals will not have hearing rights associated with this program.

Assessment process:

- A 4 ADL assessment is completed on the Hospital Decompression Assessment tool (not within Oregon ACCESS (OA)). The individual must be SPL 1-13. No other eligibility criteria will apply. Assessments may be done virtually or by reviewing medical documentation.

Setting:

- A CBC setting that is willing to accept the individual per their screening process may qualify under this program. Licensing rules that dictate whether the individual can be accepted will apply. This is considered temporary housing and tenant rights do not apply.
- CBC settings must develop care plans that are appropriate for the individual.
- In-home settings with in-home care agencies (IHCAs) are permitted under this program. HCWs may **not** be authorized.

Duration:

- The individual may reside at the CBC setting or receive services from the IHCA for no more than 90 days unless a Medicaid LTSS determination is made using the OA CA/PS assessment tool.

Rates:

- The specialized tool includes the established Medicaid standard rates. If the facility has a contracted rate, LO staff will enter this rate on the tool.
- For IHCAs, LO staff may approve up to seven hours per day multiplied by 31 days and may request additional hours through the expedited exception process.
- Room and board payments based on the established Medicaid rate are the responsibility of the individual. However, if the individual verbally attests to a hardship in making this payment to the LO, CO will cover this payment up to 90 days.
- If the individual has significant care needs that are not met by the established rate, an exception may be requested and approved prior to the placement for any setting.
    - CBC Settings: If additional staff are needed to meet the care needs of the individual, including Assisted Living Facilities, the rate is calculated at $16.00 per hour times the number of hours needed in a month multiplied by 31 days. ($16 x hours x 31). The exceptional rate may apply to individuals who are returning to their former CBC setting. For example, if the individual is already paying a CBC privately, but needs to pay more for the higher level of care, the program will cover the cost.
    - In-home Settings: The rate is calculated at $29.92 per hour times the number of hours per month multiplied by 31 days ($29.92 x hours x 31).
- Additional information about rates and exceptions can be found on the Hospital Decompression Assessment tool found on the Hospital Decompression page.

Ancillary support:

- DAT may approve any items necessary for the successful discharge of an individual to a CBC or an in-home care setting if the items are not covered or readily accessible through their medical plan; items needed during the

placement; and items needed for the successful transition out of the placement.

- LO staff may approve up to $1000 per service or good needed. Costs that exceed $1000 per service or good require CO approval. Examples include durable medical equipment, technology purchases, paying a past due bill, etc.
- APD pays through invoicing to the vendor whenever possible. Otherwise, the CBC/IHCA must pay for the service or good and be reimbursed by APD.

Program support:

- Any service options not already outlined in this document that support the successful transition of the individual may be considered. The option must be approved by executive management in CO. These requests must be emailed to SPD.Exceptions@dhsoha.state.or.us.

Payment structure:

- Payments will not be setup via the 512 system.
- Invoices from the CBC provider or IHCA will be sent to the individual assigned to the case who will verify the accuracy of the invoices and forwarded them to SPD.Exceptions@dhsoha.state.or.us
- Invoices will be approved by CO Management and submitted to the Office of Financial Services for processing.
- Eligibility for this program will not be seen in any of our systems (i.e., ONE, MMIS, etc.)

Consent:

- Individuals or their representatives must consent to the conditions of the program, which include:
  - Transitioning out of the program and service setting, if applicable, within 90 days of admission unless they are eligible for Medicaid LTSS.
  - Participate in a screening process for other APD programs, although they are not required to accept the services
  - No hearing or appeal rights

Transition to traditional Medicaid LTSS:

- Individuals who are already Medicaid eligible but who are not receiving traditional Medicaid LTSS are strongly encouraged to apply and complete the formal intake process with the LO within 45 days to transition from this program.
- Individuals who are Medicare eligible only will be evaluated and offered the opportunity to apply for Medicaid LTSS with the LO.