

**CHAPTER 411  
DIVISION 27**

**PAYMENT LIMITATIONS**

**411-027-0000 Payment Limitations in Community-Based Care**  
*(Amended 4/1/1999)*

(1) Payment for Services

(a) Division service payments under this rule shall be limited to home and community-based care services provided under Oregon's Title XIX SDSL 1915(c) Waiver.

(b) Community-based care services include, but are not limited to:

(A) In-Home Care Services (client-employed providers and home care agencies);

(B) Residential Care Facility Services;

(C) Assisted Living Facility Services;

(D) Adult Foster Home Services; and

(E) Specialized Living Services.

(2) Payment Basis

(a) Unless otherwise specified, service payment shall be based upon each client's assessed need for care as documented by the Division on the SDS 360.

(b) Payments for community-based care services are not intended to replace the resources available to a client from their natural support system of relatives, friends, and neighbors. Payment by the Division may be authorized only when the natural support system is unavailable, insufficient or inadequate to meet the needs of the client. Clients with excess income shall contribute to the cost of care

pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(c) Case plans shall be based upon the least costly means of providing adequate care consistent with client choice.

(d) SDSD/Type B AAA staff shall monitor the progress of the client. When a change occurs in the client's care needs that may warrant a change in the service payment rate, staff shall update the case plan.

### (3) Payment Limitations

(a) The total continuing cost of room and board, waived services and RN professional services contracted for a client in a community-based care setting shall not exceed the cost of the comparable nursing facility category of payment for that client. The total cost does not include payment for miscellaneous medical services authorized by the Office of Medical Assistance Programs.

(b) Notwithstanding section (3), subsection (a) of this rule, SDSD Central Office may authorize service payment rates that exceed the cost of the comparable nursing facility care when:

(A) There is a specific rehabilitation plan approved by the Division, with goals and a definite time frame for delivery, that will improve the client's self-sufficiency;

(B) Intensive convalescent care is required for a limited period of time; or

(C) Intensive long term care or special technology is required, but is otherwise available locally only in an acute care facility (hospital).

(c) If service payment is authorized under section (3), subsection (b) of this rule:

(A) The case plan shall reflect specific provider responsibilities, the time period for the delivery of services and corresponding payment rate adjustments;

(B) The Division shall give the provider written authorization for the services provided and the time period for delivery; and

(C) SDSD/Type B AAA staff shall monitor the progress of the client. When a change occurs in the client's care needs that may warrant a change in the service payment rate, staff shall update the case plan and recommend an adjustment in the service payment rate to SDSD Central Office.

(4) All service payments shall be prior authorized by the SDSD/Type B AAA local unit or by SDSD Central Office.

(5) The Division shall publish the established provider payment rate schedule. When the Division has established a rate schedule, SDSD/Type B AAA case managers may prior authorize service payments according to the payment rate for the client's living situation and based on the client's assessed need for care documented by the Division on the SDS 360.

(6) The Division shall not make payment to a spouse for providing community-based care services except for In-Home Care Services as provided in OAR Chapter 411, Division 030 (state funded spousal pay program).

(7) Flat Rate Contracts

(a) Flat Rate Contracts: The Division may authorize a service payment rate not included in the established rate schedule for residential care facilities, assisted living facilities and adult foster homes providing special services to a targeted population, pursuant to a written contract with the Division. To qualify, the facility must demonstrate to the Division that:

(A) There is a documented need for specialized services to the target population;

(B) The administrative and care staffs have sufficient program knowledge and skills to achieve program goals and provide the special services;

(C) The facility provides substantial additional services beyond

those covered under the established rate schedule;

(D) There is a comprehensive ongoing staff training program targeted to the population's needs;

(E) The facility has made any modifications necessary to provide the special services;

(F) The Medicaid clients served in the facility must on average, by assessment using the CAPS 360, demonstrate at least levels 4 and 5 of impairment as defined by the administrative rules appropriate to the facility's Medicaid service payment; and

(G) The facility has provided the special service for at least six months prior to the date on which the flat rate contract will take effect.

(i) Notwithstanding section (7), subsection (a), paragraph (G) of this rule, the Central Office may approve flat rate contracts to be effective prior to the date on which the facility will have provided the special service for six months based on:

(I) Central Office knowledge of provider ability to provide the special service; or

(II) The recommendation of the SDSD/Type B AAA local office staff; or

(III) Unmet community need for the specialized services to be offered under the contract.

(b) The facility must identify, at the time of application for the flat rate contract, the additional costs that the facility will incur to deliver the special services. The facility shall include, at a minimum, the additional staffing and training costs it will incur as a result of delivery of the special services.

(c) The Division will evaluate the information submitted by the facility, and may authorize a service payment rate in excess of the

established rate schedule. The Division shall not authorize a payment rate in excess of the Level 5 service payment rate being paid to assisted living facilities at the date that the flat rate contract becomes effective.

(d) A contract may be renewed at an appropriate payment rate on an annual basis for a facility that continues to meet the criteria stated in section (7), subsection (a) of this rule.

(A) At the time of the request for renewal, or at any other time the Division requests, the facility shall provide the Division with information on actual costs incurred in delivery of the special services. Information provided by the facility shall include the costs of staffing the special services and of training for direct care staff.

(B) The Division will evaluate the information submitted by the facility, and may authorize a service payment rate in excess of the established rate schedule. The Division shall not authorize a payment rate in excess of the Level 5 service payment rate for assisted living facilities clients at the date that the flat rate contract renewal becomes effective.

(e) Payments made to residential care facilities under this section shall receive service payment rate increases in the same way and at the same time as other residential care facilities. However, no payment increase will cause the maximum payment rate under this section of rule to exceed the Level 5 service payment rate for assisted living facilities.

(f) Payments made to adult foster homes under this section shall receive service payment rate increases in the same way and at the same time as other adult foster homes. However, no payment increase will cause the maximum payment rate under this section of rule to exceed the Level 5 service payment rate for assisted living facilities.

(g) Payments made to assisted living facilities under this section shall receive service payment rate increases in the same way and at the same time as other assisted living facilities. However, no payment

increase will cause the maximum payment rate under this section of rule to exceed the Level 5 service payment rate.

(h) Contracts executed prior to March 1, 1999 will be honored for the duration of the contract. After expiration, the facility must meet the criteria listed in section (7), subsections (a) and (b) of this rule for the Division to consider granting a flat rate contract under section (7), subsection (a) of this rule.

#### (8) Exceptions

(a) SDSD/Type B AAA local units may authorize individual exception payments greater than the established rate schedule as stated in OAR 411-027-0050 for service provided on or after March 1, 1998.

(b) If a facility provides care under a flat rate contract, individual payment exceptions to that rate must be pre-authorized by the SDSD Central Office.

#### (9) Payments for Adult Day Services

(a) Local SDSD/Type B AAA local units may authorize payments to any Medicaid-contracted adult day services program as defined in OAR 411-66-0000 through 411-66-0020.

(b) Adult day services may be authorized as part of an overall plan of care for service-eligible clients and may be used in combination with other community-based services if day services is the appropriate resource to meet a special need.

(c) Adult day services may be authorized for payment as a single service or in combination with other community-based care services. Adult day services shall not be authorized nor paid for if another provider has been authorized payment for the same service. Payments authorized for adult day services shall be included in computing the total cost of care.

(d) The Division will pay for a half day of program services when less than four hours are provided, and will pay for a full day of program services when more than four, but less than twenty-four, hours are

provided.

(10) Payments to Assisted Living Facilities (ALF's)

(a) Local SDSD/Type B AAA local units may authorize payments to any Medicaid-contracted Assisted Living Facility as defined in OAR 411-056-0005.

(b) In all instances, placement in ALFs is contingent upon the client meeting the payment levels described in section (10), subsection (c), paragraph (C) of this rule.

(c) Monthly Service Payment Determination

(A) Monthly service payment for Division clients is based on degree of impairment in each of the six Activities of Daily Living (ADL) as determined by the Division's assessment document and the payment levels described in section (10), subsection (c), paragraph (C) of this rule. The initial service plan shall be developed prior to admission and shall be revised if needed within 30 days. The service plan shall be reviewed and updated at least quarterly or more often as needed, as per OAR 411-056-0015 (2)(g).

(B) Activities of Daily Living (ADL) are weighted for purposes of determining the monthly service payment as follows:

(i) Critical activities of daily living (ADL): toileting, eating and behavior;

(ii) Less critical ADLs: mobility, bathing/personal hygiene and dressing/grooming.

(iii) Essential factors: Other essential factors considered are medical problems, structured living, medical management and other needs.

(C) Payment (Impairment) Levels:

(i) Level 5 - Client is dependent in three to six ADLs; OR

dependent in behavior AND one or two other ADLs.

(ii) Level 4 - Client is dependent in one or two ADLs; OR requires assistance in four to six ADLs plus assistance in behavior.

(iii) Level 3 - Client requires assistance in four to six ADLs; OR requires assistance in toileting, eating and behavior.

(iv) Level 2 - Client requires assistance in toileting, eating and behavior; OR requires assistance in behavior AND eating or toileting.

(v) Level 1 - Client requires assistance in two or more of the critical ADLs; OR requires assistance in any three ADLs; OR requires assistance in toileting, eating or behavior and assistance in at least one other essential factor; OR requires assistance in one critical ADL and one other ADL.

(D) The reimbursement rate for Division clients shall not be more than the rates charged private paying clients receiving the same type and quality of care.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070

**411-027-0010** (*Repealed 5/1/1991*)

**411-027-0015 Repayment of Premium Deposits for Workers' Compensation**

(*Amended 5/1/1991*)

Those providers on whose behalf the Senior and Disabled Services Division made a Workers' Compensation premium deposit in accordance with OAR 411-027-0010 (repealed February 8, 1991) shall repay the deposit amount to the Division at such time that the need for the deposit no

longer exists. The Division shall consider the need for the deposit no longer exists when certain conditions occur. Such conditions include, but are not limited to:

- (1) The provider sells, transfers, or otherwise goes out of business; or
- (2) The provider enters into bankruptcy; or
- (3) The provider's Workers' Compensation insurer no longer requires the deposit; or
- (4) The Division owes monies to a nursing facility at the time of each annual settlement. Such monies shall be applied against the premium deposit amount until such time the total deposit is recovered.

Stat. Auth.: ORS 410

Stats. Implemented: ORS 410.070

#### **411-027-0050 Exceptions to Payment Limitations in Community-Based Care**

*(Amended 7/1/1998)*

##### (1) General Provisions

(a) Exceptions may only be granted if SDSD determines:

(A) The client has care needs, documented in the case plan, that warrant a service payment exception; and

(B) The provider actually provides the exceptional service;

(b) For licensed facilities, service payment exceptions shall be based on demonstrated program costs that exceed basic service costs for direct care, administration, training and in-service education for staff and do not include consideration of costs for building, utilities or food.

##### (2) Adult Foster Care and Residential Care Facility Payment Exceptions

(a) Service payment exceptions may be authorized for individual

clients in all adult foster care or in residential care facilities by SDDS/Type B AAA unit managers according to the following criteria:

(A) The service payment rate including any exception payment shall not exceed the cost of comparable nursing facility care;

(B) Service payment exceptions may be considered only if the provider can demonstrate that frequency and intensity of services and/or staffing must be increased because of one or more of the following factors:

(i) Care of the terminally ill;

(ii) Multiple occurrences of specific, difficult behaviors on a daily basis;

(iii) Behavior that negatively affects other residents necessitating a private room;

(iv) Special technology used to meet essential life needs requiring additional training and/or supervision;

(v) Additional care needed to meet the needs of a functional quadriplegic; or

(vi) Lifts and/or transfers require more than one person; and

(C) If a service payment exception is prior authorized for a client, reassessment of the needs that require the exception payment shall occur not less frequently than once every six months.

(b) Documentation of the needs that warranted establishment of the exception payment and its continuance shall be provided to the Division by SDDS/Type B AAA local offices in a manner and at a time directed by the Division.

(3) Assisted Living Facility Payment Exceptions. No service rate exceptions are allowed in assisted living facilities.

(4) Exceptions above the established rate schedule for in-home services may only be granted when it is determined the placement is the most appropriate place for the resident, special services are necessary to meet client needs and the provider has the capability to meet those needs. Documentation of the client needs that warrant an exception payment must be in the client's file. Exception payments to the basic rate cannot be made if the provider does not perform the services.

Stat. Auth.: ORS 410.070  
Stats. Implemented: ORS 410.070

**411-027-0100 Payment for Residential Care Facility and Adult Foster Home Services**  
(Amended 7/1/1998)

The Division will reimburse for services provided to clients residing in a residential care facility or an adult foster home according to the following:

(1) The provider shall agree to accept as full payment for all services rendered to a client an amount determined pursuant to OAR 461-006-0106 for room and board, and a service payment determined by the Division pursuant to OAR 411-027-0000 or 411-027-0050.

(2) Service rates are based on the client's level of impairment and assessed need for care as documented by the Division on the SDS 360. Payment levels are assigned based on the degree of assistance a client requires with activities of daily living (mobility, eating/nutrition, continence, grooming/dressing, bathing and behavior) and certain procedures that must be performed by the provider. Service levels will be:

(a) Level 5 - The client has impairments which rate 100 or more points;

(b) Level 4 - The client has impairments which rate between 76 and 99 points;

(c) Level 3 - The client has impairments which rate between 61 and 75 points;

(d) Level 2 - The client has impairments which rate between 36 and 60 points; and

(e) Level 1 - The client has impairments which rate fewer than 36 points.

(3) Funds that would have been available for provider payments on February 28, 1998, will be converted to payments using a point system on March 1, 1998. Funds that would have been available for provider payments to relative adult foster home providers will be converted to payments using the point system on July 1, 1998.

#### (4) Payment Responsibilities

(a) Clients are entitled to retain a personal allowance plus any income disregards pursuant to applicable Adult and Family Services Division rules;

(b) Clients are responsible for payment of the room and board amount;

(c) Clients shall contribute any income in excess of the personal allowance, income disregards and room and board payments to the provider toward the service payment; and

(d) The Division shall issue payment to the provider for the difference between the service payment and the available income of the client.

(5) The provider may not charge the client, or a relative or representative of the client, for items included in the room and board or service payments or any items for which the Division or the Office of Medical Assistance Programs (OMAP) makes payment.

(6) The Division is not responsible for damages to the provider's home, facility or property or obligations entered into with the client.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070

## **411-027-0200 Personal Incidental Funds in Residential Care Facilities and Assisted Living Facilities**

*(Adopted 2/1/2000)*

(1) Each Medicaid and General Assistance resident is allowed a monthly amount for personal incidental needs. Personal incidental funds include monthly allotments as well as previously accumulated resident savings. (The present Medicaid resource limit, to maintain eligibility, is \$2,000.)

(2) The resident may manage his/her personal incidental funds or authorize the facility or another person to manage them unless that resident has been judged to be incompetent. A resident who was not adjudicated incompetent may always decide how to spend his/her own funds.

(a) The facility shall keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds;

(b) The provider shall not under any circumstances commingle, borrow from, or pledge any funds of a resident.

(c) The facility must, upon written authorization of the resident, or representative acting on behalf of the resident, accept responsibility for holding, safeguarding, spending, and accounting for these funds.

(d) Form SDS 542, Designation of Management of Personal Incidental Funds, must be completed by the resident, or representative acting on behalf of the resident, to delegate responsibility to the facility to manage the funds. The facility administrator or his/her delegee must sign the form to acknowledge responsibility for managing the resident's funds. When a facility is a resident's representative payee, it must fulfill its duties as representative payee in accordance with applicable federal regulations and state regulations which define those duties;

(e) The facility shall retain the original Form SDS 542 and copies shall be provided to the resident and SPD/AAA casemanager.

(3) The resident or their representative may, at any time, choose to

terminate the facility's responsibility for managing the personal incidental funds.

(a) A dated, written request for the facility to relinquish responsibility should be submitted by the resident/representative to the facility.

(b) The total resident personal incidental funds shall be provided to the resident/representative within one day of the request, excluding weekends and holidays.

(c) The facility shall retain the original written request and copies shall be provided to the resident and SPD/AAA casemanager.

(4) All requests to access personal incidental funds must be acted upon by the facility within one day of the request, excluding weekends and holidays.

(a) Form SDS 713, Resident Account Record, must be completed by the facility for all personal incidental fund disbursements and/or deposits. The form shall be initialed by the facility staff person making the entry. The resident account record shall show in detail with supporting documentation, all monies received on behalf of the resident and the disposition of all funds so received. Persons shopping for residents shall provide a list showing description and price of items purchased, along with payment receipts for these items.

(b) The facility shall retain the original Form SDS 713 and copies shall be provided to the resident and SPD/AAA casemanager on a quarterly basis.

(5) Funds over \$150 shall be maintained in the residents' own interest-bearing account or in an interest bearing account with a system that credits the appropriate interest specifically to each resident.

(6) Personal incidental funds may not be used to pay for services, supplies, and/or equipment that the facility is responsible for providing. Notwithstanding section (4) of this rule, prior to the disbursement of personal incidental funds, the facility shall make a reasonable effort to determine if reimbursement from another source is available to pay for a specific resident need.

(7) The facility shall not charge the resident for holding, disbursing, safeguarding, accounting for, or purchasing from personal incidental funds nor shall the cost for items charged to personal incidental funds be more than the actual purchase price charged by an unrelated supplier.

(8) The facility must be insured to cover all amounts of personal incidental funds being handled by the facility.

(9) When a facility is handling the personal incidental funds and receives notification from the resident/representative that the resident is leaving the facility, the total resident personal incidental funds shall be provided to the resident/representative within one day of the notification, excluding weekends and holidays, or any day thereafter as requested by the resident, prior to the resident's final day at the facility.

(10) Upon the death of a Medicaid or General Assistance resident, with no known surviving spouse, any personal incidental funds held by the facility for the resident shall be forwarded to the Seniors and People with Disabilities Division, Estate Administration Unit, P.O. Box 14021, Salem, OR 97309, within 10 business days of the death of the resident.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070