CHAPTER 411
DIVISION 27

PAYMENT LIMITATIONS IN COMMUNITY-BASED CARE

411-027-0000 Payment Limitations in Community-Based Care
(Temporary Effective 8/1/2004 – 1/5/2005)

(1) Payment for Services:

(a) Department service payments under this rule are limited to home and community-based care services provided under Oregon's Title XIX 1915(c) Waiver for Aged and Disabled Persons.

(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;

(E) Specialized Living Services;

(F) Adult Day Care Services; and

(G) Home-Delivered Meals.

(2) Payment Basis:

(a) Unless otherwise specified, service payment will be based upon each client's assessed need for care as documented by the Seniors and People with Disabilities cluster (SPD) Client Assessment/Planning System (CA/PS).

(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 Department 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 will contribute to the cost of care pursuant to OAR 461-160-0610 and 461-160-0620.

(c) Case plans will be based upon the least costly means of providing adequate care consistent with client choice. Client choice means that the person has a choice of services that are available within the approved Finance and Policy Analysis (FPA) rate schedule. Any services that are available at a rate higher than the FPA schedule will only be a choice if the client meets the criteria in the exception policy in OAR 411-027-0050.

(d) Service delivery area (SDA) and Type B Area Agency on Aging (AAA) staff will 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 will update the case plan.

(3) Maximum Community-Based Care Rate

(a) The monthly maximum community-based care rate is established at $3615.00.

(b) Beginning July 1 2005 and every other year thereafter, the rate will be inflated by the annual change in the DRI Index, as measured in the previous year’s fourth quarter.

(c) Finance and Policy Analysis publish the maximum community-based care rate at least annually.

(4) Payment Limitations:

(a) The total continuing cost of, waiver services for a client in a community-based care setting must not exceed the published maximum community-based care rate.

(b) Notwithstanding section (4) subsection (a) of this rule, the Department may authorize service payment rates that exceed the maximum community based care rate when:

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

(B) SPD determines that intensive convalescent care is required for a limited period of time; or

(C) SPD determines that intensive long-term care or special technology is required, but is otherwise available locally only in an acute care facility (hospital); and

(D) FPA has reviewed the costs of service to be provided and determined their reasonability.

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

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

(B) SPD and FPA will give the provider written authorization for the services provided and the time period for delivery; and

(C) SDA and Type B AAA staff will 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 will update the case plan and recommend an adjustment in the service payment rate to SPD and FPA.

(5) All service payments must be prior authorized by the SDA or Type B AAA local unit or by SPD and FPA.

(a) FPA will publish the established provider payment rate schedule. When FPA has established a rate schedule, SDA and Type B AAA long-term care case managers may prior authorize service payments

from that schedule based on the client's living situation and assessed need for care documented on the SPD CA/PS.

(b) Any rate that differs from the FPA published rate based on the client's living situation and assessed need for care must be pre-authorized by FPA and SPD.

(6) The Department will 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) Payments for Adult Day Services:

(a) Local SDA and Type B AAA units may authorize payments to any Medicaid-contracted adult day services program as defined in OAR 411-66-0000 through 411-66-0020 in accordance with the published rate schedule.

(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 will not be authorized nor paid for if another provider has been authorized payment for the same service. Payments authorized for adult day services will be included in computing the total cost of care.

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

(8) Payment For Home Delivered Meals

(a) Local SDA and Type B AAA units may authorize payments to any Medicaid-contracted home delivered meals as defined in OAR 411-

66-0000 through 411-66-0020 in accordance with the published rate schedule.

(b) Home-delivered meals 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 meals is the appropriate resource to meet a special need.

(9) Payments to Assisted Living Facilities (ALF's):

(a) Local SDA and Type B AAA 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 (7), subsection (c), paragraph (C) of this rule.

(c) Monthly Service Payment Determination:

(A) Monthly service payment for SPD clients is based on degree of impairment in each of the six Activities of Daily Living (ADL) as determined by the SPD CA/PS and the payment levels described in section (7), subsection (c), paragraph (C) of this rule. The initial service plan must be developed prior to admission and must be revised if needed within 30 days. The service plan 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 Department clients will 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
(Renumbered to OAR 411-027-0150 1/1/2002)

411-027-0025 Payment for Residential Care Facility and Adult Foster Home Services
(Renumbered from OAR 411-027-0100 1/1/2002)

The Department 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 Department 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 on the SPD CA/PS. 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) A base rate of $917 per month will be paid for all clients.

(b) Additional add-on payments will be made for clients whose assessed needs meet add-on criteria. Each add-on payment is made in the amount of $225 per month.

(A) If a client is eligible for one add-on payment, an add-on payment of $225 per month will be made in addition to the base payment.

(B) If a client is eligible for two add-on payments, a total add-on payment of $450 per month will be made in addition to the base payment.

(C) If a client is eligible for three add-on payments, a total add-on payment of $675 per month will be made in addition to the base payment.

(c) Eligibility for add-on payment(s) is made based on client needs as documented on the SPD CA/PS. A client is eligible for an add-on payment if:

(A) The client is dependent in mobility or eating or toileting; or

(B) The client demonstrates behaviors that pose a risk to the client or to others and the provider must consistently intervene to supervise or redirect; or

(C) The client's complex health condition requires daily assessment, observation and monitoring by a licensed healthcare professional and the facility has the capability to provide such service and does provide such service.

(3) Payment Responsibilities.

(a) Clients are entitled to retain a personal allowance plus any income disregards pursuant to Oregon Administrative Rules Chapter 461.

(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.

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

(4) 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 Department makes payment.

(5) The Department 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

411-027-0050 Exceptions to Payment Limitations in Community-Based Care
(Amended 1/1/2002)

(1) General Provisions. Exceptions may only be granted if the Department 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.

(2) Service payment exceptions shall be based on demonstrated program costs that exceed basic service costs for direct care and services for the individual client. Service payment exceptions do not include consideration of costs for building, utilities or food.

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

(4) All individual exceptions to the published rate in adult foster homes and residential care facilities must be pre-authorized by FPA and SPD.

(a) Rate exceptions may be authorized only for client care needs that are not paid for by the base rate or by any one of the three available add-on payments.

(b) SDA/AAA management shall approve requests for payment exception before they are transmitted to DHS.

(c) Locally approved requests for payment exception will be sent to FPA. The request must include a statement of client needs that are not paid for by the base rate or by the three available add-on

payments; a statement of how the provider proposes to meet the client needs and an estimate of the cost involved in meeting the client needs.

(d) Rate exceptions must be re-approved at reassessment of the client.

(5) 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.

(a) SDA/AAA management may authorize service payment exceptions up to the dollar amount produced by applying the hourly rate published in the FPA rate schedule to the Maximum Monthly Hours of Service in OAR 411-030-0070.

(b) Rate exceptions that exceed the amount specified in subsection (a) of this section must be pre-authorized by FPA and SPD.

(A) SDA/AAA management shall approve requests for payment exception before they are transmitted to DHS.

(B) Locally approved requests for payment exception will be sent to FPA. The request must include a statement of client needs that warrant exceptional payment; a statement of how the provider proposes to meet the client needs and an estimate of the cost involved in meeting the client needs.

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

411-027-0075 Special Payment Contracts
(Adopted 1/1/2002)

(1) The Department may authorize three different types of Special Payment Contract arrangements. These are:

(a) Supplemented Program Contract: An supplemented program contract pays a rate in excess of the published rate schedule to providers in return for additional services delivered to target populations.

(b) Consistent Revenue Contract: A consistent revenue contract allows a payment rate based on average facility casemix. The contracted rate is in the range allowed by the published rate schedule and is based on client needs.

(c) Specific Needs Setting Contract: A specific needs setting contract pays a rate in excess of the published rate schedule to providers who care for a group of clients all of whose service needs exceed the service needs encompassed in the base payment and all add-ons.

(2) Supplemented Program Contracts: FPA and SPD 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 additional services to a targeted population, pursuant to a written contract with the Department. To qualify, the facility must demonstrate to the Department that:

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

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

(f) The Medicaid clients served in the facility must demonstrate increasing need for assistance with Activities of Daily Living and cognitive abilities due to Alzheimer's Disease or other dementia.

(A) "Alzheimer's Disease" means a chronic, progressive disease of unknown cause that attacks brain cells or tissues.

(B) "Dementia" means a clinical syndrome characterized by a decline in mental function of long duration in an alert individual. Symptoms of dementia include memory loss and the loss or diminution of other cognitive abilities such as learning ability, judgement, comprehension, attention and orientation to time and place and to oneself.

(g) The facility has provided the additional service for at least six months prior to the date on which the supplemented program contract will take effect. Additionally, FPA and SPD may approve supplemented program contracts to be effective prior to the date on which the facility will have provided the additional service for six months based on:

(A) SPD experience of provider ability to provide the additional service; or

(B) The recommendation of the SDA/AAA local office staff; or

(C) Unmet community need for the additional services to be offered under the contract.

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

(i) FPA will evaluate the information submitted by the facility, and may authorize a service payment rate of $1,840.46 per month.

(j) A contract may be renewed at the appropriate payment rate on an annual basis for a facility that continues to meet the criteria stated in section (1), subsection (a) of this rule.

(A) At the time of the request for renewal, or at any other time the Department requests, the facility shall provide FPA with information on actual costs incurred in delivery of the additional services. Information provided by the facility shall be in the format prescribed by FPA and shall, at a minimum, include the costs of staffing the additional services and of training for direct care staff.

(B) FPA will evaluate the information submitted by the facility, and may re-authorize a service payment rate of $1,840.46 per month.

(k) The supplemented program contract rate may be increased only if the Legislative Assembly authorizes DHS to do so and appropriates to DHS the funds needed to pay the increase.

(3) Consistent Revenue Contracts: The Department may authorize a service payment rate not included in the established rate schedule for residential care facilities, assisted living facilities and adult foster homes that request a consistent revenue rate pursuant to a written contract with the Department.

(a) In a consistent revenue contract, the Department establishes a uniform service payment rate for all clients. The uniform service payment rate is equivalent to the average service payment rate that the Department would pay under the established rate schedule. In no case will the consistent contract payment exceed the average amount that the Department would have paid to the facility under the established rate schedule.

(b) A provider must request a consistent revenue contract in writing. The request must include the suggested payment amount and justify the calculation of that amount by attaching copies of the most recent three full calendar months Provider Client Summary form.

(A) If a request for a consistent revenue contract and the required justification are received by FPA on or before the 15th of the month, the consistent revenue contract payment amount will be effective for payment for services rendered on or after the first day of the month immediately following receipt of the request.

(B) If a request for a consistent revenue contract and the required justification are received by FPA after the 15th of the month, the consistent revenue contract payment amount will be effective for payment for services rendered on or after the first day of the second month following receipt of the request.

(c) A consistent revenue contract may be terminated by the facility by providing 30 days written notice to FPA. If a consistent revenue contract is terminated, service payments for clients will be made in accordance with the published rate schedule.

(d)The Department may terminate a consistent revenue contract by providing 30 days written notice to the facility. If a consistent revenue contract is terminated, service payments for clients will be made in accordance with the published rate schedule.

(e) Payment rates under consistent revenue contracts may be adjusted due to changes in facility casemix.

(A) The Department will review facility casemix annually at contract renewal. The determination of average facility casemix will be based on the average service payment level to which the Department would have assigned clients over the three calendar months that precede the determination.

(B) Notwithstanding Section (A) of this subsection, in the first year during which a facility is paid under a consistent revenue contract, the facility may request that the consistent revenue contract payment be recalculated after six months. The request must include the recommended payment amount and justification of that amount.

(f) Service payment rate amounts paid under consistent revenue contracts will be increased as a result of legislatively approved increases at the same time and in the same way as are other facilities of the same licensure.

(4) Specific Needs Setting contracts

(a) Specific needs settings are found in adult foster homes, residential care facilities and assisted living facilities. These settings provide community-based care for clients whose needs are not met by the published rate schedule.

(b) Determination of facility eligibility for a specific needs setting contract is at the discretion of the Department. In making its determination, the Department will consider the needs of the clients being provided care; the availability of other community long-term care options to meet client needs; the proportion of facility clients demonstrating the specific needs setting care need and other factors as the Department may determine.

(c) The provider shall submit information to the Department in the form and at the time requested in order to determine the Medicaid rate to be paid.

(d) The total rate for specific needs setting contracts shall be approved by FPA. The approved rate is a single rate paid for all Title XIX clients with the specific needs setting care need who live in the eligible facility.

Stat. Auth.: ORS 410
Stats. Implemented: ORS 410.070

411-027-0100 Payment for Residential Care Facility and Adult Foster Home Services
(Renumbered to OAR 411-027-0025 1/1/2002)

411-027-0150 Repayment of Premium Deposits for Workers' Compensation

(Renumbered from OAR 411-027-0015 1/1/2002)

Those providers on whose behalf the Senior and Disabled Services Division made a Workers' Compensation premium deposit in accordance with OAR 411-027-0010 (suspended 2-8-91 and repealed 5-1-91) 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

411-027-0200 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