DEPARTMENT OF HUMAN SERVICES
AGING AND PEOPLE WITH DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 27

PAYMENT LIMITATIONS IN HOME AND COMMUNITY-BASED SERVICES

411-027-0000 (Renumbered to OAR 411-027-0020 6/1/2008)

411-027-0005 Definitions

(Amended 09/02/2014)

(1) "AAA" means "Area Agency on Aging" as defined in this rule.

(2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by an individual for continued well-being, which are essential for health and safety. Activities include eating, dressing, grooming, bathing, personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel and bladder management), and cognition and behavior as described in OAR 411-015-0006.

(3) "ADL" means "activities of daily living" as defined in this rule.

(4) “Aging and People with Disabilities (APD)” means the division of Aging and People with Disabilities, within the Department of Human Services.

(5) “APD” means “Aging and People with Disabilities” as defined in this rule.

(4) "Area Agency on Aging (AAA)" means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to older adults and adults with disabilities in

a planning and service area. The term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210-300.

(5) "Assessment" means the process of evaluating the functional impairment levels for service eligibility, including an individual's requirements for assistance or independence in performing activities of daily living and instrumental activities of daily living and determining nursing facility services. The Department requires use of the Client Assessment and Planning System (CA/PS) as the tool used to determine service eligibility and planning.

(6) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology, service animals, general household items, or furniture used to assist and enhance an individual's independence in performing any activity of daily living.

(7) "CA/PS" means the "Client Assessment and Planning System" as defined in this rule.

(8) “Case Manager” means an employee of the Department or Area Agency on Aging, who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements the service plan and monitors the services delivered.

(9) “Central Office” means the main office of the Department, Division, or Designee.

(10) "Client Assessment and Planning System (CA/PS)":

(a) Is the single entry data system used for --

(A) Completing a comprehensive and holistic assessment;

(B) Surveying an individual's physical, mental, and social functioning; and

(C) Identifying risk factors, individual choices and preferences, and the status of service needs.

(b) The CA/PS documents the level of need and calculates the individual's service priority level in accordance with the rules in OAR chapter 411, division 015, calculates the service payment rates, and accommodates individual participation in service planning.

(11) "Consumer Choice" means an individual has been informed of alternatives to nursing facility services and has been given the choice of institutional services, Medicaid home and community-based service options, or the Independent Choices Program.

(12) "Contracted In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR chapter 333, division 536, that provides hourly contracted in-home services to individuals served by the Department or Area Agency on Aging.

(13) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices consist of the available services under the Medicaid home and community-based service options, the utilization of assistive devices, natural supports, architectural modifications, and alternative service resources (defined in OAR 411-015-0005). not paid for by the Department.

(14) "Department" means the Department of Human Services (DHS).

(15) "Exception" means the approval for payment of a service plan granted to a specific individual in their current residence (or in the proposed residence identified in the exception request) that exceeds the CA/PS assessed service payment levels for individuals residing in community-based care facilities or the maximum hours of service as described in OAR 411-030-0070 for individuals residing in their own homes or the home of a relative. The approval is based on the service needs of the individual and is contingent upon the service plan meeting the requirements in OAR 411-027-0020, OAR 411-027-0025, and OAR 411-027-0050. The term "exception" is synonymous with "exceptional rate" or "exceptional payment."

(16) "Homecare Worker" means a provider, as described in OAR 411-031-0040, that is directly employed by a consumer to provide either hourly or live-in services to the eligible consumer.

(a) The term homecare worker includes consumer-employed providers in the Spousal Pay and Oregon Project Independence Programs. The term homecare worker also includes consumer-employed providers that provide state plan personal care services to older adults and adults with physical disabilities. Relatives providing Medicaid in-home services to an individual living in the relative's home are considered homecare workers.

(b) The term homecare worker does not include Independent Choices Program providers or personal care attendants enrolled through the Office of Developmental Disability Services or the Addictions and Mental Health Division.

(17) "Hourly Services" mean the in-home services, including activities of daily living and instrumental activities of daily living, that are provided at regularly scheduled times.

(18) "IADL" means "instrumental activities of daily living" as defined in this rule.

(19) "ICP" means "Independent Choices Program" as defined in this rule.

(20) "Independent Choices Program (ICP)" means the self-directed in-home services program in which a participant is given a cash benefit to purchase goods and services identified in a service plan and prior approved by the Department or Area Agency on Aging.

(21) "Individual" means the person applying for, or eligible for, services. The term "individual" is synonymous with "client", "participant", "consumer", and "consumer-employer."

(22) "In-Home Services" mean those activities of daily living and instrumental activities of daily living that assist an individual to stay in his or her own home or the home of a relative.

(23) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in IADL are identified in OAR 411-015-0007.

(24) "Live-In Services" mean the in-home services provided when an individual requires activities of daily living, instrumental activities of daily living, and twenty-four hour availability. Time spent by any live-in employee doing instrumental activities of daily living and twenty-four hour availability are exempt from federal and state minimum wage and overtime requirements.

(25) “Natural Supports” or “Natural Support System” means resources and supports (e.g. relatives, friends, significant others, neighbors, roommates, or the community) who are willing to voluntarily provide services to an individual without the expectation of compensation. Natural supports are identified in collaboration with the individual and the potential "natural support". The natural support is required to have the skills, knowledge and ability to provide the needed services and supports.

(26) "Rate Schedule" means the rate schedule maintained by the Department at http://www.oregon.gov/DHS/spd/provtools/rateschedule.pdf. Printed copies may be obtained by contacting the Department of Human Services, Aging and People with Disabilities, ATTN: Rule Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301.

(27) "These Rules" mean the rules in OAR chapter 411, division 027.

(28) "Twenty-Four Hour Availability" means the availability and responsibility of a homecare worker to meet the activities of daily living and instrumental activities of daily living of a consumer as required by the consumer over a 24 hour period. Twenty-four hour availability services are provided by a live-in homecare worker and are exempt from federal and state minimum wage and overtime requirements.

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

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

411-027-0015 *(Renumbered to OAR 411-027-0150 1/1/2002)*

411-027-0020 Payment Limitations in Home and Community-Based Services
(Amended 09/02/2014)

(1) PAYMENT FOR SERVICES.

(a) Service payments under these rules are limited to services provided under Oregon's Medicaid State Plan K Option for individuals served through the Department’s Aging and People with Disabilities program area.

(b) Home and community-based services include but are not limited to:

(A) In-home services (consumer-employed providers and contracted in-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 services; and

(G) Home-delivered meals.

(2) PAYMENT BASIS.

(a) Unless otherwise specified, service payment is based upon an individual's assessed need for services as documented in CA/PS.

(b) Payments for home and community-based services are not intended to replace the resources available to an individual from the individual's natural support system. The Department may authorize

paid services only to the extent necessary to supplement potential or existing resources within an individual's natural supports system.

(c) An individual with excess income must contribute to the cost of services pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(d) Service plans are based upon less costly means of providing adequate services consistent with consumer’s assessed need and choice.

(e) An individual's progress is monitored by Department or AAA local office staff. When a change occurs in the individual's service needs that may warrant a change in the service payment rate, staff must update the service plan.

(3) SERVICE PAYMENTS. All service payments must be prior authorized by the Department or AAA local office staff.

(a) Department and AAA case managers authorize service payments from the rate schedule based on an individual's service program and assessed need for services documented in CA/PS.

(b) Any rate that differs from the rate schedule must be pre-authorized by the Department.

(4) RATE SCHEDULE. Services are paid at the rate in the Rate Schedule at the time of the service. The rate schedule must be updated:

(a) When there is an increase in a rate on the schedule or

(b) Thirty (30) days prior to when any rate is reduced.

(5) SPOUSAL SERVICES. The Department does not make direct payments to a spouse for providing community-based services except for in-home services as described in OAR chapter 411, division 030.

(6) PAYMENTS FOR ADULT DAY SERVICES.

(a) Payments to any Medicaid-contracted adult day services program, as described in OAR chapter 411, division 066, are authorized by Department or AAA local office staff and made in accordance with the rate schedule.

(b) Adult day services may be authorized as part of an overall plan of services for service-eligible individuals and may be used in combination with other community-based services if adult day services are the appropriate resource to meet an identified need.

(c) Department, or AAA local office staff, may authorize adult day services for payment as a single service or in combination with other home and community-based services. Adult day services are not authorized or paid for if another provider has been authorized payment for the same service. Payments authorized for adult day services are included in computing the total cost of services.

(d) The Department pays for a half day of adult day services when four or less hours of services are provided, and pays for a full day of adult day services when more than four but less than 24 hours are provided.

(7) PAYMENT FOR HOME DELIVERED MEALS.

(a) Payments to any Medicaid-contracted home delivered meals provider as described in OAR chapter 411, division 040 are authorized by Department or AAA local office staff and made in accordance with the rate schedule.

(b) Medicaid home-delivered meals may be authorized as part of an overall plan of services for service-eligible individuals and may be used in combination with other in-home services if meals are the appropriate resource to meet an identified need.

(8) PAYMENTS TO ASSISTED LIVING FACILITIES. Payments to any Medicaid-contracted assisted living facility (ALF) as defined in OAR 411-054-0005 are authorized by Department or AAA local office staff and made in accordance with the rate schedule.

(a) The monthly service payment for an individual receiving services in an ALF is based on the individual's degree of impairment in each of the six activities of daily living as determined by CA/PS and the payment levels described in paragraph (c) of this subsection. The individual's initial service plan must be developed prior to admission to the ALF and must be revised if needed within 30 days. The individual's service plan must be reviewed and updated at least quarterly or more often as needed as described in OAR 411-054-0034.

(b) Activities of daily living are weighted for purposes of determining the monthly service payment as follows:

(A) Critical activities of daily living include elimination, eating, and cognition and behavior.

(B) Less critical activities of daily living include mobility, bathing, personal hygiene, dressing and grooming.

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

(c) Payment (Impairment) Levels.

(A) Level 1 -- All Title XIX, service priority level 1-13 eligible individuals are qualified for Level 1 or greater.

(B) Level 2 -- Individual requires assistance in cognition and behavior AND elimination or mobility or eating.

(C) Level 3 -- Individual requires assistance in four to six activities of daily living OR requires assistance in elimination, eating, and cognition and behavior.

(D) Level 4 -- Individual is full assist in one or two activities of daily living OR requires assistance in four to six activities of daily living plus assistance in cognition and behavior.

(E) Level 5 -- Individual is full assist in three to six activities of daily living OR full assist in cognition and behavior AND one or two other activities of daily living.

(d) The reimbursement rate for Department individuals receiving Medicaid services shall not be more than the rates charged by private paying individuals receiving the same type and quality of services.

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

411-027-0025 Payment for Residential Care Facility and Adult Foster Home Services
(Amended 09/02/2014)

The Department reimburses for services provided to individuals residing in a residential care facility or an adult foster home according to the following:

(1) SERVICE PAYMENT. The provider must agree to accept an amount determined pursuant to OAR 461-155-0270 for room and board and a service payment determined by the Department pursuant to OAR 411-027-0020 or 411-027-0050 as payment in full for all services rendered to an individual.

(2) SERVICE RATES. Service rates are based on an individual's level of impairment and assessed need for services as documented in CA/PS. Service eligibility levels are assigned based on the degree of assistance an individual requires with activities of daily living and certain procedures that must be performed by a provider.

(a) A base rate is paid for all individuals in accordance with the rate schedule.

(b) Additional add-on payments are made for individuals whose assessed needs meet add-on criteria. Add-on payments are paid in accordance with the rate schedule.

(A) If an individual is eligible for one add-on payment, an add-on payment is made in addition to the base payment.

(B) If an individual is eligible for two add-on payments, a total of two add-on payments are made in addition to the base payment.

(C) If an individual is eligible for three add-on payments, a total of three add-on payments are made in addition to the base payment.

(c) Eligibility for add-on payments is made based on individual needs as documented in CA/PS. An individual is eligible for an add-on payment if:

(A) The individual is full assist in mobility or eating or elimination;

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

(C) The individual's medical treatments, as selected and documented in CA/PS, require daily observation and monitoring with oversight by a licensed healthcare professional, no less than quarterly, and the facility has trained staff to provide such service and does provide the service.

(3) PAYMENT RESPONSIBILITIES.

(a) An individual is entitled to retain a personal allowance plus any income disregards pursuant to OAR 461-160-0620.

(b) An individual is responsible for payment of the room and board amount pursuant to OAR 461-155-0270.

(A) An individual eligible for Medicaid under OAR chapter 410, division 200 and eligible for long term care services under OAR 411-015-0100 living in community based care facilities may be eligible for room and board assistance if the individual’s gross income is less than the room and board amount defined in OAR 461-155-0270. The Department issues a special needs payment to the facility, on the individual’s behalf, for the

difference between the individual's income and the room and board standard.

(B) An individual eligible for Medicaid under OAR chapter 410, division 200 and receiving room and board assistance must apply for all benefits for which the individual may be eligible, per OAR 410-200-0220, to continue to receive the room and board assistance. Individuals must follow all appeal options if applicable.

(c) An individual must contribute any income in excess of the personal allowance, income disregards, and room and board payments to the provider toward the service payment pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(d)The Department issues payment to the provider for the difference between the service payment and the available income of the individual.

(4) The provider may not charge the individual, or a relative or representative of the individual, for items included in the room and board or service payments for 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 individual.

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

411-027-0050 Exceptions to Payment Limitations in Home and Community-Based Services
(Amended 09/02/2014)

(1) Service payment exceptions may only be granted if the Department determines:

(a) The individual has service needs, documented in the service plan, that warrant a service payment exception; and

(b) The provider actually provides the exceptional service.

(2) Service payment exceptions shall be based on the additional hours of services required to meet the individual's service needs. The Department and AAA local office staff must monitor the individual service needs and recommend adjustments to the plan when appropriate.

(3) Service payment exceptions in Adult Foster Homes and Residential Care Facilities may be authorized only for individual service needs that are not paid for by the base rate or any of the three available add-on payments.

(4) Additional hours for Adult Foster Homes and Residential Care Facilities are paid at the hourly rate in the rate schedule. The Department does not authorize additional payment exceptions for building, utilities, food, or regular maintenance.

(5) No service rate exceptions are allowed in Assisted Living Facilities.

(6) Exceptions above the maximum monthly hours of service in OAR 411-030-0070 for in-home services, may only be granted when it is determined the placement is the most appropriate for the resident, special services are necessary to meet individual needs, and the provider has the capability to meet those needs.

(7) All individual exceptions to the assessed service need determination in Adult Foster Homes, Residential Care Facilities, or in-home settings, and renewals of exceptions, must be pre-authorized by the Department’s APD Central Office.

> (a) The Department and AAA local office staff shall approve requests for payment exception before they are transmitted to the Department’s APD Central Office.
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> (b) Locally approved requests for payment exception must be sent to the Department’s APD Central Office. The request must include:
>
> > (A) A statement of individual needs that exceed the assessed rate or the maximum monthly hours of services; and
> >
> > (B) A statement of how the individual's needs are met and the cost involved in meeting the individual's needs.

(c) The Department's APD Central Office Exceptions Committee must review and approve or deny exception requests and transmit the decision and effective date to the Department and AAA local office staff.

(d) Rate exceptions expire one year from the effective date or on the date determined by the Exceptions Committee.

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

411-027-0075 Special Payment Contracts
(Amended 09/02/2014)

(1) The Department may authorize three different types of special payment contract arrangements.

(a) Supplemented Program Contract. A supplemented program contract pays a rate in excess of the 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 case mix. The contracted rate is in the range allowed by the rate schedule and is based on individual needs.

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

(2) SUPPLEMENTED PROGRAM CONTRACTS.

(a) The Department may authorize a service payment rate not included in the 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 staff 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 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 individuals served in the facility demonstrate increasing need for assistance with activities of daily living and cognitive abilities due to Alzheimer's Disease or other dementia.

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

(ii) "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, judgment, 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 takes effect. Additionally, the Department may approve supplemented program contracts to be effective prior to the date on which the facility has provided the additional service for six months based on:

(i) The Department experience of provider ability to provide the additional service;

(ii) The recommendation of the Department and AAA local office staff; or

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

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

(b) The Department must evaluate the information submitted by the facility, and may authorize a contracted payment amount.

(c) 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)(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 the Department with information on actual costs incurred in delivery of the additional services. Information provided by the facility shall be in the format prescribed by the Department and shall, at a minimum, include the costs of staffing the additional services and of training for direct care staff.

(B) The Department must evaluate the information submitted by the facility, and may re-authorize a contracted payment amount.

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

(3) CONSISTENT REVENUE CONTRACTS. The Department may authorize a service payment rate not included in the 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 individuals. The uniform service payment rate is equivalent to the average service payment rate the Department pays under the rate schedule. In no case shall the consistent revenue contract payment exceed the average amount the Department pays to the facility under the 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 Individual Summary Form.

(A) If a request for a consistent revenue contract and the required justification are received by the Department on or before the 15th of the month, the consistent revenue contract payment amount is 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 the Department after the 15th of the month, the consistent revenue contract payment amount is 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 the Department. If a consistent revenue contract is terminated, service payments for individuals are made in accordance with the 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 individuals are made in accordance with the rate schedule.

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

(A) The Department must review facility case mix annually at contract renewal. The determination of average facility case mix is based on the average service payment level to which the Department has assigned individuals over the three calendar months that precede the determination.

(B) Notwithstanding section (3)(e)(A) of this rule, 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 a consistent revenue contract are 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 services for individuals whose needs are not met by the 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 shall consider:

(A) The needs of the individuals being provided care;

(B) The availability of other community long-term care options to meet individual needs; and

(C) The proportion of facility individuals 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 the Department. The approved rate is a single rate paid for all Title XIX individuals with the specific needs setting care need that live in the eligible facility.

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

411-027-0100 *(Renumbered to OAR 411-027-0025 1/1/2002)*

411-027-0150 Repayment of Premium Deposits for Workers' Compensation
(Amended 09/02/2014)

Those providers on whose behalf the Department 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 Department at such time that the need for the deposit no longer exists. The Department 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;

(2) The provider enters into bankruptcy;

(3) The provider's Workers' Compensation insurer no longer requires the deposit; or

(4) The Department 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 410.070
Stats. Implemented: ORS 410.070

411-027-0200 Personal Incidental Funds in Residential Care Facilities and Assisted Living Facilities *(Repealed 6/1/2008 See OAR 411-054)*