Q and A from the Jan. 2026 Mandatory Webinar – AFH and RCF Rate Methodolgy Changes

Jan. 20, 2026

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Documentation and verification

1. **Question:** Have providers been notified of the requirement for proof of payroll when case managers ask for it yearly?

   Answer: Yes, providers have received communication about this requirement. Payroll should be asked for at each renewal of an exception. This would include exceptions that are approved for less than a year.

2. **Question:** How are potential providers who are wanting an exception on someone in a hospital going to provide payroll? Are they anticipating what they will need to provide care?

   Answer: When a provider is requesting an exception for an individual who is not yet in their facility, the provider must submit a payroll report showing the caregiving hours funded by each current resident's tier and any approved exceptions. Additionally, the new 514A will require the provider to demonstrate staffing for all current residents' tiers and exceptions, as well as the staffing for the prospective resident for whom the exception is being requested.

3. **Question:** How far back do the payroll documents need to go?

   Answer: Generally, we will request 90 days of payroll records; however, we may ask for more if the provider has a history of not staffing exceptions or tiers appropriately, if there are concerns about the provider's staffing practices or if there are concerns about the validity of the provider's payroll.

4. **Question:** I imagine a lot of provider payroll records are informal (especially with family members working at an AFH). Will CO or the local staff be responsible for communicating with providers if their payroll documentation is confusing or inadequate?

   Answer: Central Office will communicate any payroll concerns in writing to the case manager. The case manager is responsible for sharing this information with the provider. Case Managers can forward the email communication from Central Office to the provider.

Exceptions

5. **Question:** AFH exception was approved through end of February 2026. Annual CA/PS was done in December 2025. Exception rate was carried on in the new 512 through end of February 2026 but the service amount is a few hundred dollars less. How to go about addressing this issue? Not sure what to tell the provider why they will be getting less money for January-February 2026. Exception was not lined up with CA/PS due dates originally because there were delays with reviewed a year ago.

Answer: Provider's rates should not be reduced due to this change if the provider is meeting the staffing requirements outlined in the resident's tier and exception, or if the resident's tier/acuity decreases. If you notice any rate decreases, reach out to the Central Office Exceptions Team at apd.cbcexceptions@odhsoha.oregon.gov.

6. **Question:** Does the exception hours requirement only apply to Medicaid residents?

   Answer: When calculating an exception, the daily hours worked only applies to individuals receiving Medicaid services. Private pay individuals are not part of this process.

7. **Question:** For AFHs who went into a higher rate 1/1/26 than their previous exceptional rate, how will they be notified that the exception requirements are no longer in place?

   Answer: There is no specific notification being provided to providers for this scenario.

8. **Question:** For new exceptions, they will not have payroll records yet. Is the process to approve for a short time and then collect those?

   Answer: Yes, since providers will be required to demonstrate that they are staffing all their current residents' tiers and any exceptions before an exception will be approved. Providers must also show that they are utilizing all caregiving hours funded by their current residents' tiers and exceptions before additional funding for a new resident will be granted. However, since this is new for providers, we will allow 30 days to begin this process and 60 days to submit the required documentation, provided they agree to start submitting legally required payroll.

9. **Question:** For those who continue to receive exceptions, will SRXQ be re-activated because it appears it is disabled at this time?

   Answer: Yes, SRXQ will become available again shortly.

10. **Question:** Have the providers received training on this and the changes to the exception process?? Or will they be relying on us to "train" them?

    Answer: A training has been developed and provided to AFH providers.

11. **Question:** How is this going to work with exception requests that were already submitted and are just waiting to be processed? Will that exception request be dismissed, added on top of the level rate, or replace the level rate that has already been set up in DHR?

    Answer: Exception requests submitted prior to 1/1/2026 will be processed and evaluated. If approved, the approval notification email will include two approval amounts: one showing the approved amount from the date of the request through 12/31/2025, and another showing the approved exceptional hours and rate for 1/1/2026 through the exception's expiration date.

12. **Question:** How would the process work for upfront exceptions?

    Answer: Providers will be required to show they are staffing all their current resident's tiers and any exceptions before we will approve an exception for an additional resident. Providers need to show they are utilizing all the caregiving hours funded by their current resident's tiers and exceptions before we will grant additional funding for an additional resident. However, since this is new to providers, we will give each provider 30 days to start this process and 60 days to get us the documentation if they agree to start providing legally required payroll. Exceptions will be terminated if the provider fails to provide the required information.

13. **Question:** I am confused because in the past, when an AFH exception rate was extended, the rate remained the same for the extension period.

    Answer: This has not changed; however, rates for exceptions approved through 1/1/2026 may reflect an increased amount, but they should not decrease.

14. **Question:** I feel like we had a transmittal a while ago asking case managers to review paperwork for exceptions, and now I see we don't need to. Is this a change?

    Answer: Case Managers and Supervisors are still expected to review the exceptions calculator and the 514A to ensure the provider's request aligns with the consumer's care needs and that they support the request. Additionally, Case Managers and Supervisors should review the new 514A to confirm that the provider has demonstrated sufficient

staffing to meet all tiers and exceptions. Case Managers are not expected to review payroll records; however, they are expected to forward these records to the Central Office team along with the new exception's calculator and the new 514A.

15. **Question:** I have an AFH exception expiring 1/31/2026. The provider needs to provide a written request for the exception and complete the new 514a? Will I need to complete the 512 and AFH exception checklist?

    Answer: Yes, the provider will need to submit a new 514A and payroll records. A new 512 will also be required. The exception checklist is not mandatory but can be helpful in ensuring the provider has submitted all required documents.

16. **Question:** If an AFH wants to apply for an exception will the prior rate from 2025 be rolled until a decision has been made or will they only receive the tier rate until a decision has been made then an underpayment be completed?

    Answer: Exceptions are not approved prior to the date the provider requests the exception in writing. However, Exception requests submitted prior to 1/1/2026 will be processed and evaluated. If approved, the provider will receive back payment. The approval notification email will include two approval amounts: one showing the approved amount from the date of the request through 12/31/2025, and another showing the approved exceptional hours and rate for 1/1/2026 through the exception's expiration date.

17. **Question:** If an exception request is approved and it takes for example a few months before the approval. Would payments be retroactive?

    Answer: Yes, exception rates can be paid retroactively if an exception is approved. However, they can only be retroactively paid from the date the provider officially requested the exception or the date the consumer moved in, whichever is later.

18. **Question:** If exception from December has not yet been submitted, since its January, are we to submit exception the new way or due to agency delay should we submit and expect the old way?

Answer: If the provider received a 10-day notice of the exception ending (which is now sent automatically via email) and submitted the request prior to the exception's expiration date, the request can be submitted using the previously used forms. However, if the provider did not submit the exception request before the expiration date, they will need to submit the new documents, and the exception will not be retroactively approved.

19. **Question:** If we find out that a provider is not providing the exception hours, do we need to do an APS report or would we need to do a fraud report?

    Answer: If the Case Manager believes abuse or neglect occurred to a resident or residents due to an exception not being staffed appropriately, that should be reported to APS. This is not a change. However, the Central Office Exceptions Team must be informed of these concerns after they have been reported to APS. Regarding fraud referrals, the Central Office Exceptions Team can complete a fraud referral when they have discovered potential fraud due to staffing issues.

20. **Question:** Is a verbal request from the AFH provider sufficient, or to be a true request date for either initial or renewal exception do they have to submit paperwork?

    Answer: The request from the provider must be in writing and date stamped or narrated.

21. **Question:** Is the expectation that the local office denies exceptions if the provider fails to provide the required documentation?

    Answer: Local offices are not required to deny exceptions; however, they are certainly welcome to, particularly in situations where the provider has clearly not provided the required documentation.

22. **Question:** Is the new tiered rate system expected to decrease the requests for exceptions from providers?

    Answer: APD anticipates a decrease in the number of exceptions, which was part of legislative goal in 2025.

23. **Question:** Is the provider completing the CBC exceptions calculator and the 514A?

Answer: Ideally, the provider should complete both the CBC Exceptions Calculator and the 514A. However, Case Managers may choose to complete the Exceptions Calculator on behalf of the provider if the provider is struggling to complete the form. The provider should always complete the 514A.

24. **Question:** Is there a reason that the Exception team cannot communicate directly with the AFH when they need clarification or further documents? Rather than having to do the telephone game through the CM to communicate to the provider and then communicate it back to the Exception Team?

    Answer: The Case Manager is the primary contact for the provider regarding exceptions. We need to ensure the Case Manager is aware of the status of the exception and agrees with any additional information being requested. Often, Case Managers can provide clarification without us needing to request information from the provider.

25. **Question:** It is great to see on the Provider Alerts page (https://www.oregon.gov/odhs/licensing/adult-foster-homes/Pages/provider-alerts.aspx) notices were sent to APD AFH providers on 12/19 about the rate change, and on 12/30 about a rate change training in Workday for them to take. However, to my knowledge, these alerts are not being sent out to DD providers, many of whom have APD residents with exceptions in their homes. Is there a plan in place for DD providers with APD consumers in their homes to receive these provider alerts?

    Answer: This is being discussed.

26. **Question:** When renewing an exception *now* in this 2026 context, we're really talking about anything beyond the tier they're assessed at, right? Theoretically, if a client is assessed at Tier 5 and the AFH owner is ok with the $7,000 per month and the 10 hours of additional care per month, then there isn't a need for any renewal documentation at all, right? Only if they want to go beyond their assessed tier is there really an exception in play, right?

    Answer: This is correct for new exceptions and for providers where the new rate for a resident is higher than what they were receiving prior to 1/1/2026. However, provider's

rate cannot be reduced due to this new methodology if they meet the hold harmless criteria.

27. **Question:** Regarding the payroll documentation that will now be required for all approved exceptions, demonstrating “hours provided to current residents”, one of my AFH operator says she doesn’t utilize a traditional payroll system. She said that their staff member only consists of herself and her spouse, so she’s been writing one yearly check to pay her spouse a lump-sum annual amount without itemizing hours worked or hourly rate. She said she’ll explore alternative methods of demonstrating services provided to current residents in lieu of traditional payroll documentation such as documenting the hourly rates and hours on a Word document. Is this considered as acceptable payroll documentation if the AFH doesn’t have a formal payroll system?

    Answer: Providers will need to begin submitting legally required payroll. Since this is a new requirement, providers will have 30 days to start submitting legally required payroll and 60 days to provide that documentation to us.

28. **Question:** Should we submit exception requests without payroll records, if they do not have them readily available?

    Answer: Yes, however, Central Office staff need to know if the provider is willing to start implementing payroll. If they are willing, they will be given 30 days to begin submitting legally required payroll and 60 days to provide that documentation to us. If they refuse, the exception will be denied.

29. **Question:** I was confused about the example of the 5 clients in one AFH. If the provider is requesting exception hours for night care needs, does the provider need to proof that he has enough staff for every 10-hour client? The example was little confusing because we have a lot of providers that don't speak English very well and explaining these details will be very confusing.

    Answer: Yes, a provider requesting an exception for night needs will be required to submit payroll records demonstrating that all additional caregiving hours are being provided as funded in each resident’s tier and any approved exceptions.

30. **Question:** What happens when an AFHs that do not ask for exceptions and now they are say a Tier 1 - Tier 5. These providers may not have additional staffing but will receive the payment. Will the CM need to be looking at these cases and having a conversation with the provider. If the provider does not want to hire an additional caregiver what then happens to the Tier, they got?

    Answer: If a provider does not have any exceptions and/or is not requesting exceptional hours, providers should provide the staffing. However, that is not being specifically monitored at this time. However, they are still required to meet each resident's care needs. Concerns about care needs not being met should be referred to the AFH's licensors and/or APS.

31. **Question:** When AFH's receive the notice from Central Office about the need for exception renewal, it will come from the Exception inbox, right? What happens if they respond directly to that email with the exception info, rather than sending it to the CM?

    Answer: 10-day notices of exception termination are being sent from the apd.cbcexceptions@odhsoha.oregon.gov email inbox. This inbox cannot receive incoming emails or responses. The notice also instructs providers to contact their Case Manager with any questions.

32. **Question:** When we are working on reviewing the exception we do not count the owner's hours, right? (As in if the owner providers care as well)?

    Answer: All tiers require a provider to be present in the adult foster home 24 hours a day, although the caregiver may sleep at night. The tiers also provide additional caregiving hours. Therefore, the 514A must show both the 24-hour caregiving coverage and the additional staffing funded by each resident's tier and any approved exceptions.

33. **Question:** Where do AFH providers go to access the updated 514A, Exception Calculator, and updated AFH/RCF Request Checklist? IM-25-123 shows where these updates forms/tools were posted on CM Tools, but it's not clear where providers go to access these forms. Are providers essentially dependent on CMs to provide them with these forms?

Answer: Providers may request these forms from the case manager or the provider tools page: https://www.oregon.gov/odhs/licensing/adult-foster-homes/pages/default.aspx.

34. **Question:** Will it be a different format for the in-home exception for this year?

    Answer: There are no changes to the in-home exceptions process at this time.

35. **Question:** Are we required to remind them about the expiration? What if they claim they didn't receive it or overlooked it?

    Answer: Providers will receive a 10 day notification in advance that their exception will be expiring soon.

36. **Question:** Who completes the exceptions calculator?

    Answer: The providers should complete it; however, case managers may assist providers with this if needed.

37. **Question:** Does the new 514A replace the 351 (Weekly Staffing Plan) form?

    Answer: Yes, that is correct. although the 351 is still a licensing requirement.

38. **Question:** Will case managers no longer be filling out the regular 514 (not the 514A)?

    Answer: The 514 will no longer be required for new exceptions or exceptions being renewed in 2026.

General / other

39. **Question:** Do consumers and/or representatives receive 512s when changes are made? Or just providers?

    Answer: Consumers are sent copies of the updated 512. For Representatives, in Oregon ACCESS on the Contacts tab, there is a space where staff can select if they want the 512 to be sent to that individual. It is titled, 'Send 512 to'. It defaults to Don't send, but staff can select Reliable Resource or Legal Representative if they want the 512 to go to that individual.

40. **Question:** Do the point only apply to the 4 ADLs, or do they also apply to areas such as bathing, dressing, housekeeping, meal prep, etc.?

    Answer: The points apply to all the ADLs/IADLs. If a 4 ADL assessment was previously completed, a full assessment is needed to determine the number of points and tier for the consumer.

41. **Question:** How much of an impact will this have on CMs in their workload?

    Answer: APD is hoping that over time, there will be less exceptions requests being submitted by AFHs, resulting in reduced workload.

42. **Question:** Is the foster home getting a copy of the points detail?

    Answer: The Adult Foster Homes received a provider alert, as well as training information, that describes how the points are calculated. If the facility provider requests a copy of the Points Detail information, staff can and should send them a printout of that information for individuals residing in their facility.

43. **Question:** Is this replacing us writing assessments? Are we now going to check the boxes for points?

    Answer: There is no impact to how assessments are being conducted.

44. **Question:** What happens when providers look at the calculator and see they could be getting more and want to go over, do CMs need to do assessments for that?

    Answer: If a consumer has had a change in condition resulting in increased care needs, a new assessment may be required prior to the exception being considered or approved. However, if the assessed care needs appear to be accurate, yet do not match the request from the provider, the request will be denied.

45. **Question:** Why is this change happening?

    Answer: The 2025 Oregon legislature mandated a rate methodology change for AFHs and RCFs.

46. **Question:** Will CMs need to do a new 512 effective 1/1/2026 due to this change?

    Answer: The 512s should have been automatically issued to providers. However, if requested, please re-issue the 512 as needed.

Licensing

47. **Question:** What is the licensor's role with this? Are they also trained on all this new process? Can we utilize them to get documentation requested?

    Answer: Licensors are not involved in the rate determinations and should not be contacted with questions related to rates.

Provider information

48. **Question:** Can AFH providers request hearings for individuals approved for services to try to change their payment?

    Answer: Providers may not request hearings regarding the approved service payment.

49. **Question:** Does this effect the AFH that are 494 care homes?

    Answer: This does not affect the Specific Needs Contract (SNC) homes.

50. **Question:** For those AFHs without professional bookkeeper services or acceptable payroll methods, would APD consider offering Acumen as a fiscal service provider, like they do for ICP?

    Answer: No, we cannot require facilities to utilize a fiscal intermediary.

51. **Question:** If the AFH has questions about how the new pay system works should case managers refer them to speak with licensing & monitoring?

    Answer: A training was created for providers that can be taken any time via Workday. The training is titled ODHS APD AFH Provider Rate Methodology Change". Also a website was created with information about this change:

https://www.oregon.gov/odhs/licensing/adult-foster-homes/pages/provider-rate-change.aspx. They may request a copy of an individual's Points Detail as it pertains to their most recent assessment.

52. **Question:** Is it appropriate to send the CA/PS and points without client consent to the AFH so they can review it before they decide to admit someone?

    Answer: The Points Details may be sent when either the consumer or the facility provider specifically requests it for the purposes of screening for admission and/or service planning. It should not be sent when not specifically requested.

53. **Question:** Payroll records are currently not in AFH OAR. How steep do you see this climb getting licensees on board?

    Answer: This will be a change for providers; however, they have received multiple communications regarding this change. We are also being flexible initially with this requirement by giving providers 30 days to comply with payroll requirements and 60 days to get us the documentation.

54. **Question:** Why were ALFs left out from this system?

    Answer: Not including Assisted Living Facilities (ALFs) was a legislative decision.

55. **Question:** Will you need daily logs, BSS reports MARs AFH service plan, incidence reports, 002N and 514?

    Answer: Potentially, the exceptions team may require BSS reports. Narratives, MARs or other documentation before renewing an exception. The 514 is no longer required for exceptions requested after 1/1/2026.

Rates and tiers

56. **Question:** Are all hold harmless exception rates good through the entire year of 2026? Or does it end when the reassessment is done during the year?

Answer: The hold harmless exception may end for a variety of reasons as discussed in APD-PT-25-023, however it may continue beyond an assessment completed in 2026. Hold harmless rates are still subject to renewal requirements and must be requested by the provider prior to their expiration.

57. **Question:** Are night care needs included in the new tiered rates?

    Answer: The additional caregiving hours funded in the tiered rates may be used for night needs. Before an exception can be granted—including those for night needs—the provider must demonstrate that they are providing the additional caregiving hours funded by each resident's tier and any approved exceptions.

58. **Question:** Are the additional hours per month?

    Answer: The additional hours are per day.

59. **Question:** Are the additional tier hours for daytime only? Are night needs separate?

    Answer: The additional caregiving hours funded in the tiered rates may be used for night needs. Before an exception can be granted—including those for night needs—the provider must demonstrate that they are providing the additional caregiving hours funded by each resident's tier and any approved exceptions.

60. **Question:** As a case manager how am I supposed to know the tier level of all the other residents if they are not assigned to my caseload?

    Answer: Staff may use the SMRQ screen and search by provider number to find information about all Medicaid recipients living in a single facility.

61. **Question:** Can the CM forms requirements be updated to include sending the 002 and the tier explanation to AFH provider at renewal to try to ensure that care needs are understood by everyone. (this would help providers better understand how/why consumers are assessed the way they are and reduce some of the back and forth between providers and CMs)?

Answer: We do not want to require the 002 to be sent in all situations. But local offices may choose to send it when a reassessment is completed regardless of the requirements listed by Central Office on the Forms Requirements tool.

62. **Question:** Do the hours over the 10 include hours spent outside of the home. For example, if a caregiver must accompany the client on a walk, or to the doctor's office?

    Answer: If the individual's needs are determined to exceed the hours funded by the tier and qualify for exceptional funding, this can include hours spent outside the home.

63. **Question:** Do we know if PACE will have been paying providers based on the new tiers?

    Answer: PACE organizations (PO) are aware of the new payment structure for CBCs. POs are paid a monthly capitation payment through MMIS (like a CCO) and the PO pays the CBC provider to provide services to its participants. POs must contract with providers to provide services to its enrolled participants, so payment structure is part of the contract negotiation(s). POs generally use the State payment information as a guide for payments to its contracted providers.

64. **Question:** Do we need to minus the care hours the AFH asked for when the client is going to day care M-F for 6 hours each time?

    Answer: A consumer cannot receive care from the providers when they are at ADS, and those hours would not be considered in an exception request.

65. **Question:** How much notice are we required to give an AFH when we are completing an assessment when their Tier Rate reduces (for example, Tier 5 to Tier 4)?

    Answer: Timely notice is not required to facility providers for facility rate changes.

66. **Question:** I noticed that on the APD Rate Methodology Presentation given in October 2025, there was a slide that seemed to indicate that in some circumstances for cognition, 6 additional points are given. This has caused some confusion, as other information just indicates that the only additional points given are the 20 additional points for SA/FA in Challenging Behaviors, and 10 additional points for FA in any cognition component. Are

there indeed circumstances where folks qualify for an additional 6 points in cognition, or are the only possible additional points the 10 or 20?

Answer: You are correct in that some of the information presented in Oct. 2025, has changed. The information presented in this session is the updated rate information which supersedes the information from the Oct. 2025 session.

67. **Question:** Is the tier level listed on the 512?

    Answer: The tier level is not printed on the 512.

68. **Question:** Not all AFHs only have Medicaid consumers so what is the process when this is the case on how many hours the AFH must fund for consumers that are already present in the home? Is there a specified number of hours for private pay that is considered when evaluating all the consumers in the home payroll records?

    Answer: Tier staffing and payroll review would only apply to Medicaid funded individuals.

69. **Question:** Once the change is made to the Full Benefit Results initial screen, changing (say) Base+3 to the new Tier level, is there going to be a way to still see/find what their 2025 Base+ level was?

    Answer: The Rate screen will continue to show both the old and the new rate for a while. We don't have an exact date when the old rate information will be removed from the screen, but staff can look at previous assessments to see the applicable rate information for those assessments.

70. **Question:** Providers 512 for 1/1/26 has the previous base rates. When will they be notified of the new tier rates for their consumers?

    Answer: Updated 512s have already been sent out.

71. **Question:** Will there be a guide for providers and CMs for the tiers and exceptions calculations?

Answer: There is a new Request Checklist and a new CBC Funding Justification Worksheet on the CM Tools website for providers to utilize in making their requests. CMs or providers can email apd.cbcexceptions@odhsoha.oregon.gov with specific questions not easily answered using those tools.

Training and communication

72. **Question:** Can case managers take the provider training just so we know what their side of the fence looks like and help with paperwork a little better?

    Answer: The training is available in Workday.

73. **Question:** Can we get an updated training on treatments? Specifically, which medications are included in the Medications requiring skilled assessment other than sliding scale insulin?

    Answer: We have updated the 'Treatments in Oregon ACCESS' tool and it is available on the Client Details page on the CM Tools website. It includes Treatment Definitions, Enhanced HCW Treatments, AFH and RCF Rate Points information and Resources for staff and providers.

74. **Question:** Is there going to be training on treatments to help with that?

    Answer: TUFSS has treatments training materials on our Learning Hub: https://wd5.myworkday.com/oregon/learning/course/4045c82217fd1002001f397579980000?type=9882927d138b100019b928e75843018d&record=32b279fed965100117793895898800000&metadataEntryPoint=%2Foregon%2Flearning.

Treatments

75. **Question:** Are there only points assessed for "complex" treatments and not treatments like daily medication management?

    Answer: Correct, only the treatments that have been considered as "complex" count for points.

76. **Question:** Can we get the link to the Treatments that are eligible for points?

    Answer: https://www.oregon.gov/odhs/providers-partners/seniors-disabilities/Documents/treatments-in-oa.pdf

77. **Question:** Is there any discussion at Central Office on aligning our definitions of the treatments with the actual definition of them? This would make it less confusing for clients and staff. An example of this would be aerosol therapy. The definition of aerosol therapy differs significantly from what we would consider for our treatments.

    Answer: Treatment definitions have been updated in the new Treatments in Oregon ACCESS tool on the Client Details page on the CM Tools website.

78. **Question:** For medication, some are once a day while some are 3 times a day. Is that we count the one with the highest frequency?

    Answer: Yes, that is correct.

OREGON DEPARTMENT OF Human Services
Aging and People with Disabilties
Medicaid Services and Supports
500 Summer St. NE, E-10
Salem, OR 97301-1076
503-945-5600
odhs.info@odhs.oregon.gov
www.oregon.gov/odhs