Oregon Department of Human Services
Aging and People with Disabilities
Oregon Administrative Rules

Chapter 411
Division 70

Nursing Facilities/Medicaid – Generally and Reimbursement

411-070-0000 Purpose
(Amended 09/25/2024)

The purpose of these rules is to control payment for nursing facility services provided to Medicaid residents.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0005 Definitions
(Amended 03/03/2022)

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-085-0005 apply to the rules in OAR chapter 411, division 070:

(1) "Accrual Method of Accounting" means a method of accounting where revenues are reported in the period they are earned, regardless of when they

are collected, and expenses are reported in the period they are incurred, regardless of when they are paid.

(2) "Active Treatment" means the implementation of an individualized care plan developed under and supervised by a physician and other qualified mental health professionals that prescribes specific therapies and activities.

(3) "Activities of Daily Living" means activities usually performed in the course of a normal day in an individual's life such as eating, dressing, grooming, bathing, personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition and behavior.

(4) "Aging and People with Disabilities (APD)" means the program area of Aging and People with Disabilities, within the Department of Human Services.

(5) "Alternative Services" mean individuals or organizations offering services to persons living in a community other than a nursing facility or hospital.

(6) "Area Agency on Aging (AAA)" means the Department of Human Services designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors and individuals with disabilities in a planning and service area. For the purpose of these rules, 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 to 410.300.

(7) "Augmented Rate" means the additional compensation to a nursing facility who qualifies for the Quality and Efficiency Incentive Program described in OAR 411-070-0437. The augmented rate is a daily rate of $9.75 and is in addition to the rate a nursing facility would otherwise receive. The Department may pay the augmented rate to a qualifying facility for a period not to exceed four years from the date the facility purchases bed capacity under the Quality and Efficiency Incentive Program.

(8) “Bariatric rate” means a rate paid for a Medicaid resident of a nursing facility if the resident meets the criteria described in OAR 411-070-0087.

(9) "Basic Flat Rate Payment" and "Basic Rate" means the statewide standard payment rate for all long-term services provided to a Medicaid resident of a nursing facility, except for services reimbursed through another Medicaid payment source. The "Basic Rate" is the bundled payment rate, unless the resident qualifies for the complex medical rate, the ventilator assisted program rate, the bundled pediatric rate or the bariatric rate (instead of the basic rate).

(10) "Bi-PAP" means bi-level positive airway pressure/spontaneous timed.

(11) "Behavioral Health" means the program within the Health Systems Division (HSD) within the Oregon Health Authority (OHA), responsible for addictions and mental health services.

(12) "Capacity" means licensed nursing beds multiplied by number of days in operation.

(13) "Case Manager" means a Department of Human Services or Area Agency on Aging employee 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.

(14) "Cash Method of Accounting" means a method of accounting where revenues are recognized only when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for them.

(15) "Categorical Determinations" mean the provisions in the Code of Federal Regulations (42 CFR 483.130) for creating categories that describe certain diagnoses, severity of illness, or the need for a particular service that clearly indicates that admission to a nursing facility is normally needed or that the provision of specialized services is not normally needed.

(a) Membership in a category may be made by the evaluator only if existing data on the individual is current, accurate, and of sufficient scope.

(b) An individual with mental illness or developmental disabilities may enter a nursing facility without a PASRR Level II evaluation if criteria of a categorical determination are met as described in OAR 411-070-0043(2)(a) - (2)(c).

(16) "Certification" and "Certification for the Categorical Determination of Exempted Hospital Discharge" means the attending physician has written orders for the individual to receive skilled services at the nursing facility.

(17) "Certified Program" means a hospital, private agency, or an Area Agency on Aging certified by the Department of Human Services to conduct private admission assessments in accordance with ORS 410.505 through 410.530.

(18) "Change of Ownership" means a change in the individual or legal organization that is responsible for the operation of a nursing facility. Change of ownership does not include changes in personnel, e.g., a change of administrators. Events that change ownership include, but are not limited to, the following:

(a) The form of legal organization of the owner is changed (e.g., a sole proprietor forms a partnership or corporation);

(b) The title to the nursing facility enterprise is transferred to another party;

(c) The nursing facility enterprise is leased or an existing lease is terminated;

(d) Where the owner is a partnership, any event occurs which dissolves the partnership;

(e) Where the owner is a corporation, it is dissolved, merges with another corporation that is the survivor, or consolidates with one or more other corporations to form a new corporation; or

(f) The facility changes management via a management contract.

(19) "Compensation" means the total of all benefits and remuneration, exclusive of payroll taxes and regardless of the form, provided to or claimed by an owner, administrator, or other employee. Compensation includes, but is not limited to:

(a) Salaries paid or accrued;

(b) Supplies and services provided for personal use;

(c) Compensation paid by the facility to employees for the sole benefit of the owner;

(d) Fees for consultants, directors, or any other fees paid regardless of the label;

(e) Key man life insurance;

(f) Living expenses, including those paid for related persons; or

(g) Gifts for employees in excess of federal Internal Revenue Service reporting guidelines.

(20) "Complex Medical Payment" and "Complex Medical" means the statewide standard supplemental payment rate for a Medicaid resident of a nursing facility whose service is reimbursed at the basic rate if the resident needs one or more of the medication procedures, treatment procedures, or rehabilitation services listed in OAR 411-070-0091, for the additional licensed nursing services needed to meet the resident’s increased needs.

(21) "Continuous" means more than once per day, seven days per week. Exception: If only skilled rehabilitative services and no skilled nursing services are required, "continuous" means at least once per day, five days per week.

(22) "Costs Not Related to Resident Services" means costs that are not appropriate or necessary and proper in developing and maintaining the operation of a nursing facility. Such costs are not allowable in computing reimbursable costs. Costs not related to resident services include, for example, cost of meals sold to visitors, cost of drugs sold to individuals who are not residents, cost of operation of a gift shop, and similar items.

(23) "Costs Related to Resident Services" mean all necessary costs incurred in furnishing nursing facility services, subject to the specific provisions and limitations set out in these rules. Examples of costs related to resident services include nursing costs, administrative costs, costs of employee pension plans, and interest expenses.

(24) “COVID-19 Pandemic” is an ongoing pandemic of coronavirus disease 2019 (COVID-19), caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

(25) "CPAP" means continuous positive airway pressure.

(26) "CPI" means the consumer price index for all items and all urban consumers.

(27) "Day of Admission" means an individual being admitted, determined as of 12:01 a.m. of each day, for all days in the calendar period for which an assessment is being reported and paid. If an individual is admitted and discharged on the same day, the individual is deemed present on 12:01 a.m. of that day.

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

(29) "Developmental Disability" means "developmental disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(30) "Direct Costs" mean costs incurred to provide services required to directly meet all the resident nursing and activity of daily living service needs. Direct costs are further defined in OAR 411-070-0359 and OAR 411-070-0465. Examples: The person who feeds food to the resident is directly meeting the resident's needs, but the person who cooks the food is not. The person who is trained to meet the resident's needs incurs direct costs whereas the person providing the training is not. Costs for items that are capitalized or depreciated are excluded from this definition.

(31) "DRI Index" means the "HCFA or CMS Nursing Home Without Capital Market Basket" index, which is published quarterly by DRI/McGraw - Hill in the publication, "Global Insight Health Care Cost Review".

(32) “Emergency Health Care Center (EHCC)” is a designated existing licensed nursing facility, in response to the COVID-19 pandemic, designed to provide long term care services to individuals that have tested positive for COVID-19. The purpose of the stay is to allow an individual to recover in an environment meeting their needs.

(33) “Employee Retention Payment Reimbursement Program” means the program described in OAR 411-070-0436 designed to support nursing facilities with employee retention by providing reimbursement to facilities who meet criteria.

(34) "Enhanced Wage Add-on Program" means the program described in OAR 411-070-0438 designed to provide additional compensation to facilities who meet the criteria.

(35) "Essential Nursing Facility" means a nursing facility that serves predominantly rural and frontier communities as designated by the Office of

Rural Health that is located more than 32 miles from another nursing facility or from a hospital that has received a formal notice of Critical Access Hospital (CAH) designation from the Centers for Medicare and Medicaid Services and that is currently contracted to provide swing bed services for Medicaid-eligible individuals.

(36) "Exempted Hospital Discharge" for PASRR means an individual seeking temporary admission to a nursing facility from a hospital as described in OAR 411-070-0043(2)(a).

(37) "Facility" or "Nursing Facility" means an establishment that is licensed and certified by the Department of Human Services as a nursing facility. A nursing facility also means a Medicaid certified nursing facility only if identified as such.

(38) "Fair Market Value" means the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.

(39) "Generally Accepted Accounting Principles" mean the accounting principles approved by the American Institute of Certified Public Accountants.

(40) "Goodwill" means the excess of the price paid for a business over the fair market value of all other identifiable, tangible, and intangible assets acquired, or the excess of the price paid for an asset over its fair market value.

(41) "Health Systems Division (HSD)" means a Division, within the Oregon Health Authority, responsible for coordinating the medical assistance programs within the State of Oregon including, but not limited to the Oregon Health Plan Medicaid demonstration and the State Children's Health Insurance Program.

(42) "Historical Cost" means the actual cost incurred in acquiring and preparing a fixed asset for use. Historical cost includes such planning costs as feasibility

studies, architects' fees, and engineering studies. Historical cost does not include "start-up costs" as defined in this rule.

(43) "Hospital-Based Facility" means a nursing facility that is physically connected and operated by a licensed general hospital.

(44) "Indirect Costs" mean the costs associated with property, administration, and other operating support (real property taxes, insurance, utilities, maintenance, dietary (excluding food), laundry, and housekeeping). Indirect costs are further described in OAR 411-070-0359 and OAR 411-070-0465.

(45) "Individual" means a person who receives, or is expected to receive, nursing facility services.

(46) "Intellectual Disability" means "intellectual disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(47) "Interrupted-Service Facility" means an established facility recertified by DHS following decertification.

(48) "Level I" means a component of the federal PASRR requirement. Level I refers to the identification of individuals who are potential nursing facility admissions who have indicators of mental illness or developmental disabilities (42 CFR 483.128(a)).

(49) "Level II" means a component of the federal PASRR requirement. Level II refers to the evaluation and determination of whether nursing facility services and specialized services are needed for individuals with mental illness or developmental disability who are potential nursing facility admissions, regardless of the source of payment for the nursing facility service (42 CFR 483.128(a)). Level II evaluations include assessment of the individual’s physical, mental, and functional status (42 CFR 483.132).

(50) "Level of Care Determination" means an evaluation of the intensity of a person’s health service needs. The level of care determination may not be used to require that the person receive services in a nursing facility.

(51) "Medicaid Occupancy Percentage" means the total Medicaid bed days divided by total resident days.

(52) "Mental Illness" means a major mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV-TR) limited to schizophrenic, paranoid and schizoaffective disorders, bipolar (manic-depressive), and atypical psychosis. "Mental Illness" for pre-admission screening means having both a primary diagnosis of a major mental disorder (schizophrenic, paranoid, major affective and schizoaffective disorders, or atypical psychosis) and treatment related to the diagnosis in the past two years. Diagnoses of dementia or Alzheimer's are excluded.

(53) "Necessary Costs" mean costs that are appropriate and helpful in developing and maintaining the operation of resident facilities and activities. Necessary costs are usually costs that are common and accepted occurrences in the field of long term nursing services.

(54) "New Admission" for PASRR purposes means an individual admitted to any nursing facility for the first time. It does not include individuals moving within a nursing facility, transferring to a different nursing facility, or individuals who have returned to a hospital for treatment and are being admitted back to the nursing facility. New admissions are subject to the PASRR process (42 CFR 483.106(b)(1), (3), (4)).

(55) "New Facility" means a nursing facility commencing to provide services to individuals.

(56) "Nursing Aide Training and Competency Evaluation Program (NATCEP)" means a nursing assistant training and competency evaluation program

approved by the Oregon State Board of Nursing pursuant to ORS chapter 678 and the rules adopted pursuant thereto.

(57) "Nursing Facility Financial Statement (NFFS)" means Form DHS 35, or Form DHS 35A (for hospital-based facilities), and includes an account number listing of all costs to be used by all nursing facility providers in reporting to the Department of Human Services for reimbursement.

(58) "Occupancy Rate" means total resident days divided by capacity.

(59) "Official Bed Count Measurement" means the number of licensed nursing facility beds as of October 7, 2013 and the beds being developed by facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December 1, 2012 or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013.

(60) "Ordinary Costs" mean costs incurred that are customary for the normal operation.

(61) "Oregon Medical Professional Review Organization (OMPRO)" means the organization that determines level of services, need for services, and quality of services.

(62) "Pediatric Rate" means the statewide standard payment rate for all long term services provided to a Medicaid resident under the age of 21 who is served in a pediatric nursing facility or a self-contained pediatric unit.

(63) "Perquisites" mean privileges incidental to regular wages.

(64) "Personal Incidental Funds" mean resident funds held or managed by the licensee or other person designated by the resident on behalf of a resident.

(65) "Placement" means the location of a specific place where health services can be adequately provided to meet the service needs.

(66) "Pre-Admission Screening (PAS)" means the assessment and determination of a potential Medicaid-eligible individual's need for nursing facility services, including the identification of individuals who can transition to community-based service settings and the provision of information about community-based alternatives. This assessment and determination is required when potentially Medicaid-eligible individuals are at risk for admission to nursing facility services. PAS may include the completion of the federal PASRR Level I requirement (42 CFR, Part 483, (C)-(E)), to identify individuals with mental illness or intellectual or developmental disabilities.

(67) "Pre-Admission Screening and Resident Review (PASRR)" means the federal requirement, (42 CFR, Part 483, (C)-(E)), to identify individuals who have mental illness or developmental disabilities and determine if nursing facility service is required and if specialized services are required. PASRR includes Level I and Level II functions.

(68) "Prior Authorization" means the local Aging and People with Disabilities or Area Agency on Aging office participates in the development of proposed nursing facility care plans to assure the facility is the most suitable service setting for the individual. Nursing facility reimbursement is contingent upon prior authorization.

(69) "Private Admission Assessment (PAA)" means the assessment that is conducted for non-Medicaid residents as established by ORS 410.505 to 410.545 and OAR chapter 411, division 071, who are potential admissions to a Medicaid-certified nursing facility. Service needs are evaluated, and information is provided about long-term service choices. A component of private admission assessment is the federal PASRR Level I requirement, (42 CFR, Part 483.128(a)), to identify individuals with mental illness or developmental disabilities.

(70) "Provider" means an entity, licensed by Aging and People with Disabilities, responsible for the direct delivery of nursing facility services.

(71) "Provider Preventable Condition (PPC)" means a condition listed below caused by the provider:

(a) Foreign object retained after treatment;

(b) Stage III and IV pressure ulcers;

(c) Falls and trauma;

(d) Manifestations of poor glycemic control;

(e) Catheter-associated urinary tract infection;

(f) Medication error; or

(g) Surgical site or wound site infection.

(72) "Quality and Efficiency Incentive Program" means the program described in OAR 411-070-0437 designed to reimburse quality nursing facilities that voluntarily reduce bed capacity that increases occupancy levels and enhances efficiency with the goal of slowing the growth of system-wide costs.

(73) "Reasonable Consideration" means an inducement that is equivalent to the amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.

(74) "Related Organization" means an entity that is under common ownership or control with, or has control of, or is controlled by the contractor. An entity is deemed to be related if it has 5 percent or more ownership interest in the other. An entity is deemed to be related if it has capacity derived from any financial or other relationship, whether or not exercised, to influence directly or indirectly the activities of the other.

(75) "Resident" means a person who receives nursing facility services.

(76) "Resident Days" mean the number of occupied bed days.

(77) "Resident Review" means a review conducted by the Addictions and Mental Health Division for individuals with mental illness or by the Aging and People with Disabilities Division for individuals with developmental disabilities who are residents of nursing facilities. The findings of the resident review may result in referral to PASRR Level II (42 CFR 483.114).

(78) "Restricted Fund" means a fund in which the use of the principal or principal and income is restricted by agreement with, or direction by, the donor to a specific purpose. Restricted fund does not include a fund over which the owner has complete control. The owner is deemed to have complete control over a fund that is to be used for general operating or building purposes.

(79) "Specialized Services for Mental Illness" means mental health services delivered by an interdisciplinary team in an inpatient psychiatric hospital for treatment of acute mental illness.

(80) "Specialized Services for Intellectual or Developmental Disabilities" means:

(a) For individuals with intellectual or developmental disabilities under age 21, specialized services are equal to school services; and

(b) For individuals with t intellectual or developmental disabilities over age 21, specialized services mean:

(A) A consistent and ongoing program that includes participation by the individual in continuous, aggressive training and support to prevent loss of current optimal function;

(B) Promotes the acquisition of function, skills, and behaviors necessary to increase independence and productivity; and

(C) Is delivered in community-based or vocational settings at a minimum of 25 hours a week.

(81) "Start-Up Costs" mean one-time costs incurred prior to the first resident being admitted. Start-up costs include, but are not limited to, administrative and nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs. Start-up costs do not include such costs as feasibility studies, engineering studies, architect's fees, or other fees that are part of the historical cost of the facility.

(82) "Supervision" means initial direction and periodic monitoring of performance. Supervision does not mean the supervisor is physically present when the work is performed.

(83) "These Rules" mean the rules in OAR chapter 411, division 070.

(84) "Title XVIII" and "Medicare" means Title XVIII of the Social Security Act.

(85) "Title XIX," "Medicaid," and "Medical Assistance" means Title XIX of the Social Security Act.

(86) "Uniform Chart of Accounts (Form DHS 35)" means a list of account titles identified by code numbers established by the Department of Human Services for providers to use in reporting their costs.

(87) "Ventilator" means a device to provide breathing assistance to individuals. This includes both positive and negative pressure devices.

(88) "Ventilator Assisted Program" means a program that provides services to residents who are dependent on an invasive mechanical ventilation as means of life support as defined in OAR 411-090-0110.

(89) "Ventilator Assisted Program Unit" means a unit that meets the Ventilator Assisted Program criteria.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, ORS 414.065

411-070-0010 Conditions for Payment

(Amended 12/1/2009)

Nursing facilities must meet the following conditions in order to receive payment under Title XIX (Medicaid):

(1) CERTIFICATION.

(a) The facility must be in compliance with Title XIX federal certification requirements.

(b) Except as provided in section (1)(c) of this rule, all beds in the facility must be certified as nursing facility beds.

(c) A facility choosing to discontinue compliance with section (1)(b) of this rule may elect to gradually withdraw from Medicaid certification but must comply with all of the following:

(A) Notify SPD in writing within 30 days of the certification survey that it elects to gradually withdraw from the Medicaid Program;

(B) Request Medicaid reimbursement for any resident who resided in the facility, or who was eligible for right of return under OAR 411-088-0050 or right of readmission under OAR 411-088-0060, on the date of the notice required by this rule. If it appears the resident may be eligible within 90 days, such request may be initiated;

(C) Retain certification for any bed occupied by or held for any resident who is found eligible for Medicaid until the bed is vacated by:

(i) The death of the resident; or

(ii) The transfer or discharge of the resident pursuant to the transfer rules in OAR chapter 411, division 088.

(D) All Medicaid recipients exercising rights of return or readmission under the transfer rules must be permitted to occupy a Medicaid certified bed; and

(E) Notify in writing all persons applying for admission subsequent to notification of gradual withdrawal that, should the person later become eligible for Medicaid assistance, that reimbursement would not be available in that facility.

(2) CIVIL RIGHTS, MEDICAID DISCRIMINATION.

(a) The facility must meet the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(b) The facility must not discriminate based on source of payment. The facility must not have different standards of transfer or discharge for Medicaid residents except as required to comply with this rule.

(c) The facility must accept Medicaid payment as payment in full. The facility must not require, solicit, or accept payment, the promise of payment, a period of residence as a private pay resident, or any other consideration as a condition of admission, continued stay, or provision of care or service from the resident, relatives, or any one designated as a "responsible party".

(d) No applicant may be denied admission to a facility solely because no family member, relative, or friend is willing to accept personal financial liability for any of the facility's charges.

(e) The facility may not request or require a resident, relative, or "responsible party" to waive or forego any rights or remedies provided under state or federal law, rule, or regulation.

(3) PROVIDER AGREEMENT, FACILITY PAYMENT.

(a) The facility must sign a formal provider agreement with SPD.

(b) The facility must file a NFFS with SPD within 90 days after the end of its fiscal year.

(c) The facility must bill SPD in accordance with established rules and guidelines.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0015 Denial, Termination or Non-Renewal of Provider Agreement

(Amended 2/1/2006)

(1) Failure to Comply. The Department reserves the right to deny, terminate or not renew contracts with providers who fail to comply with OAR 411-070-0000 through 411-070-0470 relating to nursing facility services.

(2) Notice. The Department will give the provider 30 day's written notice, by Certified Mail, before the effective date of the denial, termination or non-renewal. The notice will include the basis of the Department decision, advise the provider of the right to an informal conference to give the opportunity to refute the Department findings in writing.

(3) Information Conference:

(a) A request for an informal conference must be received by the Department prior to the effective date of the denial, termination or non-renewal;

(b) A written notice of the Department's decision reached in an informal conference will be sent to the provider by Certified Mail. This notice will

also advise the provider of his or her right to a hearing, if requested within 30 days of mailing the notice.

(4) Hearing. When a hearing is requested, it will be conducted in accordance with OAR chapter 461, division 025.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0020 On-Site Reviews

(Amended 2/1/2006)

The facility must allow periodic on-site reviews of Medicaid residents as required by federal regulations.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0025 Basic Flat Rate Payment (Basic Rate)

(Amended 12/1/2009)

(1) PAYMENT. SPD may authorize payment at the basic rate if a Medicaid resident requires daily, intermittent licensed nurse observation and continuous nursing care and has a physician's order for nursing facility care. When determining the payment rate, SPD shall consider the stability of the medical condition, the health care needs of the individual, and the individual's ability to maintain themselves in a less restrictive setting. An individual who qualifies for reimbursement at the basic rate must:

(a) Have chronic medical problems that are stabilized but not cured and have a need for supervision in a structured environment to maintain or restore stability and prevent deterioration;

(b) Require assistance for a combination of health care needs either because of a physical or psycho-social disabling condition; or

(c) Have insufficient personal and community resources available to provide for either section (1)(a) or (1)(b) of this rule.

(2) DOCUMENTATION. The professional nursing staff of the nursing facility must keep sufficient documentation in the resident's clinic record to justify the basic rate payment determination in accordance with these rules and must make it available to SPD upon request.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0027 Complex Medical Add-On Payment

(Amended 03/09/2015)

(1) PAYMENT. APD may provide payment for a complex medical add-on (in addition to the basic rate) when the resident requires one or more of the treatments, procedures, and services listed in OAR 411-070-0091, for the additional licensed nursing services needed to meet the resident’s increased needs.

(2) APD may pay the complex medical add-on only as long as the resident’s needs meet one or more of the treatments, procedures, and services listed in OAR 411-070-0091 and the facility maintains the required documentation.

(3) DOCUMENTATION. The licensed nursing staff of the nursing facility must keep sufficient documentation pertinent to the qualified complex medical add-on procedure codes in the resident's clinical record to justify the complex medical add-on payment determination in accordance with these rules (refer to OAR 411-070-0091) and must make it available to APD upon request.

(4) COMPLEX MEDICAL ADD-ONS PROHIBITED. APD may not provide complex medical add-on payments for a facility with a waiver that allows a reduction of eight or more hours per week from required licensed nurse staffing hours.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0028 Bariatric Authorization and Payment

(Adopted 07/01/2020)

(1) PRIOR AUTHORIZATION. APD may authorize payment for the bariatric rate when a Medicaid individual's needs meet the criteria listed in OAR 411-070-0087. A nursing facility must obtain prior authorization from the Department prior to admitting or submitting payment for a bariatric individual using a form designated by the Department.

(2) APD shall issue a decision regarding prior authorization within seven business days of receipt of the form described in section (1) of this rule. APD may extend this timeframe for up to ten additional business days pursuant to written notice to the nursing facility if APD requires further information from the nursing facility in order to make a prior authorization determination. If APD does not issue a decision within the timeframes described in this paragraph, prior authorization shall be deemed to be granted on the day the required timeframe expires.

(3) Prior authorization provided pursuant to this rule shall be effective as of the date APD issues the decision or prior authorization is deemed to be granted pursuant to section (2) of this rule or, if the nursing facility submits the form described in section (1) of this rule after admitting the resident, on the date of admission if that date occurs no more than seven calendar days prior to submission of the form.

(4) PAYMENT. For a Medicaid individual who meets the criteria in OAR 411-070-0087, the bariatric rate will be effective from the date a prior authorization from the Department is in effect to the last date the individual meets the criteria.

(5) DOCUMENTATION. The licensed nursing staff of the facility must maintain a weekly nursing note of sufficient documentation pertinent to the bariatric individual in the clinical record to justify the bariatric payment determination in accordance with OAR 411-070-0087. This documentation must be available to APD upon request.

(6) Bariatric per diem rates shall cover all services in the bundled rate (OAR 411-070-0085) as well as all services, equipment, supplies and costs related to bariatric services.

(7) BARIATRIC RATE PROHIBITED. APD may not provide bariatric payments for a facility with a waiver that allows a reduction of eight or more hours per week from required licensed nurse staffing hours.

(8) OVERPAYMENT FOR BARIATRIC MEDICAID PAYMENTS. The Department may collect monies that were overpaid to a facility for any period the Department determines the individual's condition or service needs did not meet the criteria for an eligible individual or determines the facility did not maintain the required documentation per (5) of this rule. The Department shall issue an order to the facility that includes the determination described in this paragraph and the facts supporting the determination as well as the amount of overpayment the Department seeks to recoup.

(9) ADMINISTRATIVE REVIEW.

(a) If a provider disagrees with the order of the Department regarding authorization pursuant to section (1) of this rule or overpayment pursuant to section (8) of this rule, the provider may either request from APD an informal administrative review of the decision or appeal the order as described in this paragraph.

(b) If the provider requests an informal administrative review, the provider must submit its request for review in writing within 30 days of receipt of the notice.

(A) The provider must submit documentation, as requested by APD and as the provider may choose to further submit to substantiate its position.

(B) APD shall notify the provider in writing of its informal decision within 45 days of APD's receipt of the provider's request for review.

(C) APD's informal decision shall be an order in other than a contested case and subject to review pursuant to ORS chapter 183.

(c) A provider who disagrees with the order issued pursuant to section (9) of this rule may appeal the order pursuant to a contested case proceeding. The provider must submit an appeal in writing within 60 days of receipt of the order.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0029 Pediatric Rate

(Amended 12/1/2009)

(1) The pediatric rate shall be for those facilities meeting the criteria established in OAR 411-070-0452 as pediatric nursing facilities or as self-contained pediatric units.

(2) The pediatric rate shall constitute the total rate payable by SPD on behalf of the individual.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0033 Post Hospital Extended Care Benefit

(Temporary effective 01/01/2026 through 06/29/2026)

(1) The post hospital extended care benefit (OAR 410-120-1210(4)) is an Oregon Health Plan benefit that consists of a stay of up to one hundred (100) days in a nursing facility to allow discharge from hospitals.

(2) The post hospital extended care benefit must be prior authorized by pre-admission screening for individuals not enrolled in managed care.

(3) To be eligible for the post hospital extended care benefit, the individual must meet all of the following:

(a) Be receiving Oregon Health Plan benefit;

(b) Not be Medicare eligible;

(c) Have a medically-necessary, qualifying hospital stay consisting of:

(A) A Medicaid-paid admission to an acute-care hospital bed, not including a hold bed, observation bed, or emergency room bed.

(B) The stay must consist of three or more consecutive days, not counting the day of discharge.

(d) Transfer to a nursing facility within 30 days of discharge from the hospital;

(e) Need skilled nursing or rehabilitation services on a daily basis for a hospitalized condition meeting Medicare skilled criteria that may be provided only in a nursing facility meaning:

(A) The individual is at risk of further injury from falls, dehydration, or nutrition because of insufficient supervision or assistance at home;

(B) The individual's condition requires daily transportation to a hospital or rehabilitation facility by ambulance; or

(C) It is too far to travel to provide daily nursing or rehabilitation services in the individual's home.

(4) The individual may qualify for another one hundred (100) day post-hospital extended care benefit only if the individual has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in this rule.

(5) Individuals eligible for the one hundred (100) day post-hospital extended care benefit are not eligible for long term care nursing facility or Medicaid home and community-based services unless the individual meets the eligibility criteria in OAR 411-015-0100 or OAR 411-320-0080.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0035 Complex Medical Add-On Effective Start and End Dates and Administrative Review

(Amended 03/09/2015)

(1) Effective Complex Medical Add-On Start and End Dates

(a) Complex Medical Add-On Start Date:

(A) Admission of any Medicaid resident whose condition or service needs meet the criteria for a complex medical add-on procedure code; or

(B) A current Medicaid resident whose condition or service needs change and now meets the criteria for a complex medical add-on procedure code. This includes a readmission or return of a Medicaid

resident following a leave of absence from the nursing facility whose needs meet add-on criteria.

(b) Complex Medical Add-On End date - For a resident whose condition or service needs meet a complex medical add-on procedure code, the complex medical add-on is effective only until the last date the resident's condition or need continues to meet complex medical add-on procedure code criteria.

(2) ADMINISTRATIVE REVIEW. If a provider disagrees with the decision of APD's Complex Medical Add-On Coordinator to make or deny an adjustment in the complex medical add-on payment for a Medicaid resident, the provider may request from APD an administrative review of the decision. The provider must submit its request for review in writing within 30 days of receipt of the notice to make or deny the adjustment. The provider must submit documentation, as requested by APD, to substantiate its position. APD shall notify the provider in writing of its informal decision within 45 days of APD's receipt of the provider's request for review. APD's informal decision shall be an order in other than a contested case and subject to review pursuant to ORS 183.484.

(3) OVERPAYMENT FOR COMPLEX MEDICAL ADD-ONS. APD shall collect monies that were overpaid to a facility for any period APD determines the resident's condition or service needs did not meet the criteria for the complex medical add-on or determines the facility did not maintain the required documentation.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0040 Screening, Assessment, and Resident Review

(Amended 12/1/2009)

(1) INTRODUCTION. All individuals who are candidates for admission to a Medicaid-certified nursing facility must be assessed to evaluate their service

needs and preferences and must receive information about community-based, alternative services, and resources that can meet the individual's service needs and are safe, least restrictive, and potentially less costly than comparable nursing facility services.

(2) PRE-ADMISSION SCREENING. A pre-admission screening (PAS) as defined in OAR 411-070-0005 is required for potentially Medicaid eligible individuals who are at risk for nursing facility services.

(a) PAS includes:

(A) An assessment;

(B) The determination of an individual's service eligibility for Medicaid-paid long term care or post-hospital extended care services in a nursing facility;

(C) The identification of individuals who can transition to community-based service settings;

(D) The provision of information about community-based services and resources to meet the individual's needs; and

(E) Transition planning assistance as needed.

(b) PAS is conducted in conjunction with the individual and any representative designated by the individual.

(c) The PAS assessment shall be conducted by a case manager or other qualified SPD or AAA representative using SPD's Client Assessment and Planning System (CA/PS) tool, and other standardized assessment tools and forms approved by SPD.

(d) A PAS may be completed based on information obtained by phone or fax only to authorize Title XIX post-hospital benefits in a nursing facility

when short-term nursing facility services are needed. A face-to-face assessment including the discussion of alternative community-based services and resources shall be completed within seven days of the initial, short term nursing facility service approval.

(e) Payment for nursing facility services may not be authorized by SPD until PAS has established that nursing facility services are required based on the individual's service needs and Medicaid financial eligibility has been established.

(3) PRIVATE ADMISSION ASSESSMENT. A private admission assessment (PAA) is required for individuals with private funding who are referred to Medicaid-certified nursing facilities established by ORS 410.505 through ORS 410.545 and OAR chapter 411, division 071.

(4) PRE-ADMISSION SCREENING AND RESIDENT REVIEW. A pre-admission screening and resident review (PASRR) as described in OAR 411-070-0043 is required for individuals, regardless of payment source, with either mental illness or developmental disabilities who need nursing facility services.

(5) RESIDENT REVIEW. Title XIX regulations require utilization review and quality assurance reviews of Medicaid residents in nursing facilities. The reviews carried out by the authorized utilization review organization must meet these requirements:

(a) Staff associated with SPD are required to maintain service plans on all SPD residents in nursing facilities. The frequency of their service plan update shall vary depending on such factors as the resident's potential for transition to home or community-based care and federal or state requirements for resident review.

(b) Authorized representatives of SPD or the authorized utilization review organization must have immediate access to SPD residents and to facility

records. "Access" to facility records means the right to personally read charts and records to document continuing eligibility for payment, quality of care, or alleged abuse. SPD or the authorized utilization review organization representative must be able to make and remove copies of charts and records from the facility's property as required to carry out the above responsibilities.

(c) SPD or the authorized utilization review organization representatives must have the right to privately interview any SPD residents and any facility staff in carrying out the above responsibilities.

(d) SPD or the authorized utilization review organization representatives must have the right to participate in facility staffings on SPD residents.

Statutory/Other Authority: ORS 410.070, 410.535, 414.065
Statutes/Other Implemented: ORS 410.070, 410.535, 414.065

411-070-0043 Pre-Admission Screening and Resident Review (PASRR)

(Amended 03/09/2015)

(1) INTRODUCTION. PASRR was mandated by Congress as part of the Omnibus Budget Reconciliation Act of 1987 and is codified in Section 1919(e)(7) of the Social Security Act. Final regulations are contained in 42 CFR, Part 483, subparts C through E. The purpose of PASRR is to prevent the placement of individuals with mental illness or intellectual or developmental disabilities in a nursing facility unless their medical needs clearly indicate that they require the level of service provided by a nursing facility. Categorical determination, as described in section (2) of this rule, are groupings of individuals with mental illness or intellectual or developmental disabilities who may be admitted to a nursing facility without a PASRR Level II evaluation.

(2) CATEGORICAL DETERMINATIONS.

(a) Exempted hospital discharge:

(A) The individual is admitted to the nursing facility directly from a hospital after receiving acute inpatient care at the hospital; or

(B) The individual is admitted to the nursing facility directly from a hospital after receiving care as an observation-status; and

(C) The individual requires nursing facility services for the condition for which he or she received care in the hospital; and

(D) The individual's attending physician has certified before admission to the facility that the individual is likely to require nursing facility services for 30 days or less.

(b) End of life care for terminal illness. The individual is admitted to the nursing facility to receive end of life care and the individual has a life expectancy of six months or less.

(c) Emergency situations with nursing facility admission not to exceed seven days unless authorized by AAA or APD staff.

(A) The individual requires nursing facility level of service; and

(B) The emergency is due to unscheduled absence or illness of the regular caregiver; or

(C) Nursing facility admission is the result of protective services action.

(3) PASRR includes three components.

(a) PASRR LEVEL I. PASRR Level I is a screening process that is conducted prior to nursing facility admission for all individuals applying as new admissions to a Medicaid certified nursing facility regardless of the

individual's source of payment. The purpose of the screening is to identify indicators of mental illness or intellectual or developmental disabilities that may require further evaluation {42 CFR 483.128} or if categorical determinations, as described in section (2) of this rule, which verify that the nursing facility service is required.

(A) PASRR Level I screening is performed by AAA or APD authorized staff, private admission assessment (PAA) programs, professional medical staff working directly under the supervision of the attending physician, or by organizations designated by DHS.

(B) Documentation of PASRR Level I screening is completed using a APD-designated form.

(C) If there are no indicators of mental illness or intellectual or developmental disabilities or if the individual belongs to a categorically determined group, the individual may be admitted to a nursing facility subject to all other relevant rules and requirements.

(D) If PASRR Level I screening determines that an individual has indicators of mental illness and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact AMH and request a PASRR Level II evaluation.

(E) If PASRR Level I screening determines that an individual has indicators of intellectual or developmental disabilities and no categorical determinations are met, then the individual cannot be admitted to a nursing facility. The Level I assessor must contact APD and request a PASRR Level II evaluation.

(F) Except as provided in section (3)(a)(F)(ii) of this rule, nursing facilities must not admit an individual without a completed and

signed PASRR Level I screening form in the individual's resident record.

(i) Completion of the PASRR Level I form under sections (3)(a)(A) through (3)(a)(F) of this rule does not constitute prior authorization of payment. Nursing facilities must still obtain prior authorization from the local AAA or APD office as required in OAR 411-070-0035.

(ii) A nursing facility may admit an individual without a completed and signed PASRR Level I form in the resident record provided the facility has received verbal confirmation from the Level I assessor that the screening has been completed and a copy of the PASRR Level I form will be sent to the facility as soon as is reasonably possible.

(iii) The original or a copy of the PASRR Level I form must be retained as a permanent part of the resident's clinical record and must accompany the individual if he or she transfers to another nursing facility.

(b) PASRR LEVEL II. PASRR Level II is an evaluation and determination of whether nursing facility service and specialized services are needed for an individual who has been identified through the PASRR Level I screening process with indicators of mental illness or intellectual or developmental disabilities who does not meet categorical determination criteria (42 CFR 483.128).

(A) Individual's identified with indicators or mental illness or intellectual or developmental disabilities as a result of PASRR Level I screening are referred for PASRR Level II evaluation and determination.

(B) PASRR Level II evaluations and determinations are conducted by AMH for individuals with mental illness or by APD for individuals with intellectual or developmental disabilities.

(C) PASRR Level II evaluations result in a determination of an individual's need for nursing facility services and specialized services (42 CFR 483.128-136) consistent with federal regulations established by the Social Security Act, Section 1919(e)(7)(C).

(D) Pursuant to 42 CFR 483.130(l), the written determination must include the following findings:

(i) Whether a nursing facility level of services is needed;

(ii) Whether specialized services are needed;

(iii) The placement options that are available to the individual consistent with these determinations; and

(iv) The rights of the individual to appeal the determination.

(E) The PASRR Level II evaluation report must be sent to the individual or their legal representative, the individuals attending physician, and the admitting or retaining nursing facility. In the case of an individual being discharged from the hospital, the discharging hospital must receive a copy of the PASRR evaluation report as well {42 CFR 483.128 (l)(1)-(3)}.

(F) Denials of nursing facility service are subject to appeal {OAR 137-003, OAR 461-025 & 42 CFR Subpart E}.

(c) RESIDENT REVIEW. Resident reviews are conducted by AMH for individuals with indicators of mental illness or APD for individuals with intellectual or developmental disabilities who are residents of nursing

facilities. Based on the findings of the resident review, a PASRR Level II may be requested. {42 CFR 483.114}.

(A) All residents of a Medicaid certified nursing facility may be referred for resident review when symptoms of mental illness develop.

(i) Resident review for individuals with indicators of mental illness that require further evaluation must be referred to the local Community Mental Health Program who shall determine eligibility for PASRR Level II evaluations.

(ii) The resident review form, part A, must be completed by the nursing facility. The resident review must be performed in conjunction with the comprehensive assessment specified by the AMH, in accordance with OAR 411-086-0060.

(B) All individuals identified as having intellectual or developmental disabilities through the PASRR Level I screening process that are admitted to a nursing facility must receive a resident review. A resident review must be conducted within seven days if the nursing facility admission is due to an emergency situation {OAR 411-070-0043(2)(c)(A)-(C)}, within 20 days if the nursing facility admission is due to other categorical determinations {OAR 411-070-0043(2)(a)-(b)}, and annually, or as dictated by changes in resident's needs or desires.

(i) The resident review must be completed by APD or designee.

(ii) The resident review must be completed using forms designated by APD.

(4) SPECIALIZED SERVICES.

(a) Specialized services for individuals with mental illness are not provided in nursing facilities. Individuals with mental illness who are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

(b) Specialized services for individuals with intellectual or developmental disabilities under age 21 are equal to school services and must be based on the Individualized Education Plan.

(c) Specialized services for individuals with intellectual or developmental disabilities over age 21 are not provided in nursing facilities. Individuals with intellectual or developmental disabilities over age 21 that are determined to need specialized services as a result of PASRR Level II evaluation and determination must be referred to another setting.

(5) RESPITE CARE. Respite care in nursing facilities for individuals with mental illness, intellectual, or developmental disabilities is approved under the following conditions:

(a) For individuals with mental illness, a nursing facility admission for respite care must be authorized by AMH and for individuals with intellectual or developmental disabilities, a nursing facility admission for respite care must be authorized by APD Central Office;

(b) Nursing facility respite stay must be limited to no more than a total of 56 respite days within a calendar year although APD may grant exceptions to this limit at its discretion;

(c) Nursing facility level of service must be required to meet a severe medical condition that excludes care needs due to mental illness or intellectual or developmental disabilities*;* and

(d) There must not be a viable community care setting available that is appropriate to meet the individual's respite care needs as determined by section (5)(a) of this rule.

Statutory/Other Authority: ORS 410.070, 410.535, 414.065
Statutes/Other Implemented: ORS 410.070, 410.535, 414.065

411-070-0045 Facility Payments

(Amended 3/1/2008)

(1) PRIOR AUTHORIZATION. The Department may reimburse a nursing facility for services provided to a Department resident only if prior authorized after the Department has participated in development of the placement plan and is satisfied that the placement is justified and most suitable for the person according to the Department care plan. The Department may not reimburse a nursing facility for services rendered prior to the date of referral to the Department. A nursing facility must verify that the local SPD/Type B AAA where the facility is located is involved in the placement.

(2) The facility must confirm an individual's financial eligibility for Medicaid payment of any nursing facility service with the local office. Medicaid eligibility is based on the requirements outlined in OAR chapter 461. The facility is responsible for collecting resident liability from the resident or their responsible party.

(3) PAYMENT TO PROVIDER. Provider payments will be made following the month of service. For billing, the Department will mail Form SDS 483, Invoice and Payment Authorization, to each facility.

(4) RESIDENT'S INCOME. A resident's income, exclusive of the authorized allowance for personal incidental needs and other prior authorized special needs, will be offset as a credit against the established Department rate paid to that facility.

(5) REDUCED PAYMENT FOR ABUSE.

(a) If abuse of a resident, according to the provisions of ORS 441.630 to ORS 441.685, is substantiated by the Department, the Department may reduce the payment for the resident(s) for the month the abuse occurred, and until such time as the Department determines the conditions leading to the abuse have been corrected.

(A) The facility will receive payment for services provided for the resident as determined by the Department. This determination will be based on the absence of appropriate services that resulted in the substantiated abuse of a resident.

(B) The reduced payment may not be considered a reduction in benefits for the resident.

(b) The Department will notify the facility by certified mail at least 15 days prior to taking action to reduce payment.

(A) The notice will include the basis of the Department decision, the effective date of the reduced payment, the amount of the reduced payment, and will advise the facility of their right to request review by the Assistant Director if such request is made in writing within 30 days of the receipt of the notice.

(B) If a request for review is made, the Assistant Director will include the basis of the Department decision, the effective date of the reduced review and all material relating to the allegation of resident abuse and to the reduction in payment. The Assistant Director will include the basis of the Department decision, the effective date of the reduced determination, based upon review of the material, whether or not to sustain the decision to reduce payments to the facility and

will notify the facility of the decision within 20 days of receiving the request for review.

(C) If the Assistant Director determines not to sustain the decision to reduce payments, the reduction will be lifted immediately. Otherwise, the reduction in payment will remain in effect until the Department determines the conditions leading to the abuse have been corrected.

(D) If the decision to reduce payment is sustained, the payment reduction will not be recovered in the year end settlement.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0050 Days Chargeable

(Amended 2/1/2006)

The Department will pay for the day of admission but not for the day of discharge, transfer, or death except as provided for in OAR 411-070-0110. When the day of admission is the same as the day of discharge, the Department will only pay for one day.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0075 Rates - Facilities in Oregon

(Amended 07/01/2020)

(1) The daily rate of payment for Oregon facilities will be the basic rate.

(2) A nursing facility may receive payment for complex medical rate if all of the criteria in OAR 411-070-0091 is met.

(3) A nursing facility may receive payment for the ventilator assisted program rate if all of the criteria in OAR 411-070-0092 is met.

(4) A nursing facility may receive the pediatric rate if all of the criteria in OAR 411-070-0452 is met.

(5) A nursing facility may receive the bariatric rate if all of the criteria in OAR 411-070-0087 is met.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0080 Out-of-State Rates

(Amended 12/1/2009)

Out-of-state facilities in areas contiguous to Oregon shall be paid for eligible individuals who are receiving temporary care while alternative placement in Oregon is being located. Payment shall be made at the facility's Medicaid rate established by the state in which the facility is located, or the maximum rate paid to Oregon nursing facilities for a comparable payment level, whichever is less. The maximum rate for out-of-state purposes is Oregon's basic rate plus the complex medical add-on, if determined to be appropriate, or the pediatric rate, if warranted. The facility must submit a copy of the Assurance and Compliance (HHS 690), certifying its compliance with the Civil Rights Act of 1964. The facility must also submit their current approved nursing facility Medicaid rate to SPD. An Oregon resident shall be returned to Oregon when proper placement may be made and it is feasible to do so.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0085 Bundled Rate

(Amended 3/1/2008)

(1) PURPOSE. The nursing facility rate established for a facility is a bundled rate and includes all services, supplies and facility equipment required for services.

(2) SERVICES AND SUPPLIES.

(a) The following services and supplies required to provide services in accordance with each resident's care plan are included in the bundled rate:

(A) All nursing services defined in OAR 411-086-0110 through OAR 411-086-0160;

(B) All support services and supplies associated with the required nursing services;

(C) All activity services, supplies and staffing as defined in OAR 411-086-0230;

(D) All social services, supplies and staffing as defined in OAR 411-086-0240;

(E) All dietary services, supplies and staffing as defined in OAR 411-086-0250;

(F) All professional consultant services;

(G) All services of the facility medical director;

(H) Management of resident funds, including purchase of items;

(I) Room and board, including:

(i) Special diets and non-pumped food supplements; and

(ii) Laundry, whether performed by the facility staff or an outside provider, including laundering and marking of resident's personal clothing and bedding;

(J) Miscellaneous services and supplies, including:

(i) Items stocked by the facility in gross supply and administered individually on physician's order;

(ii) Items owned or rented by the facility that are utilized by individual residents but are reusable and are routinely expected to be available in a nursing facility;

(iii) Shaves, haircuts, supplies and shampoos as required for grooming and cleanliness, whether performed by facility staff or by an outside provider; and

(iv) Transportation provided in vehicles that are owned or leased by the facility or by any person who holds an ownership interest in the facility.

(b) Items included within the bundled rate must meet all of the following criteria:

(A) Item(s) are medically appropriate;

(B) Item(s) are most effective and least costly means to meet the individuals' needs; and

(C) Item(s) are allowed in the state plan.

(c) The Oregon Health Plan will continue to provide coverage for specified items and equipment in accordance with OAR chapter 410, division 122. No entitlement to any item is created for any resident in a nursing facility based solely on the listing of an item in OAR chapter 410, division 122, as potentially included in the nursing facility bundled rate. Oregon Health Plan limits on duration, scope and/or frequency of provision of the item(s) may not apply to the bundled rate if the facility needs to provide the item(s) in excess of the limits in order to meet resident needs. Nursing facilities are not required to purchase all specified codes, forms, sizes or varieties of the

items listed in OAR chapter 410, division 122, so long as the residents' service needs are met. Nursing facilities are not required to honor individual preferences for specific types of equipment and supplies.

(d) The bundled rate pays for all equipment and supplies, unless the item(s) is specified as not paid for by the bundled rate. Equipment and supplies paid for in the bundled rate include:

(A) Oxygen and oxygen equipment, including concentrators, unless the oxygen provided exceeds 1,000 liters in a 24-hour period;

(B) Glucose monitors and diabetic equipment;

(C) Nebulizers and nebulizer supplies;

(D) Ostomy supplies;

(E) Urological supplies;

(F) Resident lifts except as specified in Appendix A to this rule;

(G) Toilet supplies, except as specified in Appendix A to this rule;

(H) Miscellaneous supplies;

(I) Surgical dressings;

(J) Incontinence supplies;

(K) All medically necessary wheelchairs and wheelchair accessories except:

(i) As specified in Appendix A to this rule; or

(ii) If at the time of admission, the individual's expected length of stay in the nursing facility is 30 days or less as confirmed on a

written statement from the individual's attending physician, and the individual has a physician's order for the same wheelchair for on-going use in the individual's home and meets Department of Medical Assistance Programs (DMAP) criteria for a tilt-in-space wheelchair;

(L) Suction pumps and supplies;

(M) Tracheostomy supplies;

(N) Canes and crutches;

(O) Standing and positioning aides;

(P) Walkers;

(Q) Hospital beds, except as specified in Appendix A to this rule or if an exception need exists as determined by the DMAP prior authorization process;

(R) Pressure reducing support services, except as specified in Appendix A to this rule;

(S) Hospital bed accessories, except as specified in Appendix A to this rule;

(T) Bath supplies; and

(U) Over the counter medications as defined in Appendix B to this rule.

(e) The following services and supplies are NOT included in the bundled rate:

(A) Therapy services provided to residents by outside providers;

(B) Medical services by physicians or other practitioners other than the services required by OAR 411-086-0200;

(C) Radiology services, laboratory services and podiatry services;

(D) Transportation for residents to and from medical services in vehicles that are not owned or leased by the facility or by any person who holds an ownership interest in the facility;

(E) Biologicals (e.g., immunization vaccines);

(F) Hyperalimentation ;

(G) Prescription pharmaceuticals; or

(H) Ventilators.

Statutory/Other Authority: ORS 414.065, 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0087 Bariatric Criteria and Services

(Amended 11/01/2023)

(1) A Medicaid eligible individual qualifies for the bariatric reimbursement rate if the individual has a physician diagnosis of obesity with a BMI>40 and the individual meets the following criteria as defined in OAR chapter 411, division 015:

(a) Two-person full assist with ambulation or transfers; and

(b) Full assist in one of the following: cognition, eating or elimination.

(2) If an individual meets the criteria documented in OAR 411-070-0087, and the Department has authorized the bariatric rate, the facility must provide one (1) additional Certified Nursing Assistant (CNA), for each shift, above the licensing staffing standard in OAR 411-086-0100(5), for the third through fifth approved

individuals for the bariatric rate. Another CNA is then required, for each shift, for every additional five (5) individuals receiving the bariatric rate. For example:

(a) For the first two (2) approved individuals, the facility must meet the requirements in OAR 411-086-0100(3).

(b) For three (3) to five (5) approved individuals, one CNA would be required above staffing standard, for each shift.

(c) For six (6) to ten (10) approved individuals, two (2) CNAs would be required above staffing standard, for each shift.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0091 Complex Medical Add-On Services

(Amended 08/26/2022)

(1) LICENSED NURSING SERVICES. If a Medicaid resident qualifies for payment at the basic rate and if the resident's condition or service needs are determined to meet one or more of the procedures, routines, or services listed in this rule, and the nursing facility maintains documentation per OAR 411-070-0027, APD may pay a complex medical add-on payment (in addition to the basic rate) for the additional licensed nursing services needed to meet the resident's increased needs.

(a) Medication Procedures.

(A) M-1 -- Administration of medication, at least daily, requiring skilled observation and judgment for necessity, dosage, and effect, for example new anticoagulants. (This category is limited to non-routine subcutaneous injections and does not include insulin, or the infrequent adjustments of current medications). The facility must maintain a daily nursing note.

(B) M-2 -- Intravenous injections or infusions, heparin locks used daily or continuously for hydration or medication. The facility must maintain a daily nursing note. For total parenteral nutrition (TPN) the facility must maintain daily documentation on a flow sheet and must maintain a weekly nursing note.

(C) M-4 -- Intramuscular medications for unstable condition used at least daily. The facility must maintain a daily nursing note.

(D) M-5 -- External infusion pumps used at least daily. This does not include external infusion pumps when the resident is able to self bolus. The facility must maintain a daily nursing note.

(E) M-6 -- Hypodermoclysis - daily or continuous use. The facility must maintain a daily nursing note.

(F) M-7 -- Peritoneal dialysis, daily, and Hemodialysis, at least 2-3 times a week for in-house dialysis. This does not include residents who can do their own exchanges. The facility must maintain a daily nursing note.

(b) Treatment Procedures.

(A) T-1 -- Nasogastric, Gastrostomy or Jejunostomy tubes used daily for feedings. The facility must maintain daily information on a flow sheet and a weekly nursing note.

(B) T-2 -- Nasopharyngeal suctioning, twice a day or more. Tracheal suctioning, as required, for a resident who is dependent on nursing staff to maintain airway. The facility must maintain a daily nursing note.

(C) T-3 -- Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more. The facility must maintain a daily nursing note.

(D) T-4 -- Ventilator dependence. Services for a resident who is dependent on nursing staff for initiation, monitoring, and maintenance. The facility must maintain a daily nursing note.

(c) Skin or Wound.

(A) S-1 -- Is limited to visible Stage III or IV pressure ulcers that require aggressive treatment with documented expectation of ulcer resolution. The facility must maintain a weekly wound assessment and a weekly nursing note. A healing Stage III or IV pressure ulcer that has the visual appearance of a Stage II pressure ulcer cannot be considered eligible for purposes of complex medical criteria.

The pressure ulcer is eligible for add-on until the last day the ulcer is visibly a Stage III pressure ulcer. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident's needs meet or continue to meet complex medical add-on criteria.

(i) Pressure ulcer means any skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include decubitus ulcers.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

(B) S-2 -- Open wounds as defined by dehisced surgical wounds or surgical wounds not closed primarily that require aggressive treatment and are expected to resolve. The facility must maintain a weekly wound assessment and a weekly nursing note.

(C) S-3 -- Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III. The facility must maintain a weekly wound assessment and a weekly nursing note. The stasis ulcer is eligible for add-on until the last day the ulcer is visually equivalent to a Stage III, or if the stasis ulcer is an infected, chronic Stage III or IV, it is eligible for add-on until it is no longer infected and returns to previous chronic Stage III or IV state. For complex medical add-on, facilities must stage the ulcer as it is visualized in appearance in accordance to the below definitions for determining if a resident's needs meet or continue to meet complex medical add-on criteria.

(i) Stasis ulcer means a skin ulcer, usually in the lower extremities, caused by altered blood flow from chronic vascular insufficiency, also referred to as venous insufficiency, lymphedema, arterial insufficiency, or peripheral vascular disease.

(ii) Stage II means a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

(iii) Stage III means a full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

(iv) Stage IV means a full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

(v) A healing Stage III or IV stasis ulcer that has the visual appearance of a Stage II stasis ulcer cannot be considered eligible for purposes of complex medical criteria.

(vi) A chronic Stage III or IV stasis ulcer that is no longer infected and has returned to previous chronic Stage III or IV status cannot be considered eligible for purposes of complex medical criteria.

(d) O-4 – Insulin Dependent Diabetes Mellitus (IDDM).

(A) Unstable IDDM in a resident who requires sliding scale insulin; and

(i) Exhibits signs or symptoms of hypoglycemia or hyperglycemia, or both;

(ii) Requires nursing or medical interventions such as extra feeding, glucagon, or additional insulin, and transfer to emergency room; and

(iii) Is having insulin dosage adjustments.

(B) The facility must maintain a daily nursing note. A Medication Administration Record is required when sliding scale insulin or other medication related to the IDDM has been administered. While all three criteria do not need to be present on a daily basis, the resident must be considered unstable. A resident with erratic blood sugars, without a need for further interventions, does not meet this criteria.

(e) Other.

(A) O-1 -- Professional Teaching. Short term, daily teaching pursuant to discharge or a self-care plan. The facility must maintain a teaching plan and a weekly nursing note.

(B) O-2 -- Emergent medical or surgical problems, requiring short term licensed nursing observation and assessment. Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical or surgical problem. The facility must maintain a nursing note every shift.

(C) O-3 -- Emergent Behavior Problems -- Emergent behavior is a sudden, generally unexpected change or escalation in behavior of a resident that poses a serious threat to the safety of self or others and requires immediate intervention, consultation, and a care plan. Eligibility for the add-on will be until the resident no longer requires additional licensed nursing observation and assessment for this medical problem. The facility must maintain a nursing note every shift.

(f) Effective September 1, 2012, the Department shall no longer provide the complex medical add-on for Provider Preventable Conditions (PPC).

(A) Nursing facilities may not receive complex medical add-on if the need for the complex medical add-on was caused by a PPC and the need for complex medical add-on did not exist prior to treatment or intervention.

(B) No reduction in payment for a PPC shall be imposed on a provider when the condition defined as a PPC for a particular individual occurred outside of the nursing facility or prior to admission.

(C) Regardless of payment requests, a nursing facility must report each PPC event to the Department through a Department approved reporting system.

(2) R-1 -- REHABILITATION SERVICES.

(a) Physical Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(b) Speech Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(c) Occupational Therapy -- At least five days every week. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(d) Any combination of physical therapy, occupational therapy, and speech therapy at least five days every week qualifies. The facility must maintain the therapist's notes and a weekly nursing progress note related to the rehabilitation services being provided.

(e) Respiratory Therapy -- At least five days every week by a respiratory therapist. These services must be authorized by Medicare, Medicaid Oregon Health Plan, or a third party payor. The facility must maintain the therapist's notes and a weekly nursing progress note.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0092 Ventilator Assisted Program - Medicaid Payment

(Amended 9/4/2020)

(1) PAYMENT- A Medicaid eligible individual qualifies for the Ventilator Assisted Program reimbursement rate if the:

(a) Individual meets the criteria described in section (2) of this rule; and

(b) The Nursing facility providing the ventilator services maintains an active endorsement pursuant to OAR chapter 411, division 90.

(2) An individual qualifies for reimbursement at the Ventilator Assisted Program rate if the individual:

(a) Is chronically dependent on an invasive mechanical ventilator to sustain life;

(b) Requires the ongoing use of a CPAP or Bi-Pap to sustain life; or

(c) Is receiving necessary support and services during the transition from mechanical ventilation to a lower level of service.

(3) Ventilator dependent per diem rates shall cover all services in the bundled rate (OAR 411-070-0085) as well as all services, equipment, supplies and costs related to ventilator services. This includes services necessary to accommodate the needs of a person who qualifies for the Ventilator Assisted Program Medicaid reimbursement pursuant to this rule. The following services and supplies are not included in the Ventilator Assisted Program rate:

(a) Therapy services provided to residents by outside providers, excluding respiratory therapy and speech therapy required by OAR 411-090-0180.

(b) Medical services by physicians or other practitioners excluding the services required by OAR 411-086-0200 and the Ventilator Assisted Program Medical services required by OAR 411-090-0180.

(c) Radiology services, laboratory services, and podiatry services, excluding Ventilator Assisted Program laboratory services related to 411-090-0180.

(d) Transportation for residents to and from medical services in vehicles that are not owned or leased by the facility or by any person who holds an ownership interest in the facility.

(e) Biologicals (e.g., immunization vaccines).

(f) Hyperalimentation.

(g) Prescription pharmaceuticals.

(h) Electronic devices to promote individual's communication and quality of life.

(4) ENDORSEMENT- Providers endorsed in accordance with OAR 411-090-0120 for participation in the Ventilator Assisted Program shall receive payment in the form of 235% of the basic nursing facility rate established in accordance with OAR 411-070-0442.

(5) VENTILATOR ASSISTED PROGRAM PAYMENT PROHIBITED. APD may not provide Ventilator Assisted Program payments to a facility:

(a) With a waiver that allows a reduction of required licensed nurse staffing or certified nurse staffing.

(b) For an Individual whose needs require non-acute continuous positive airway pressure (CPAP) or bi-level positive airway pressure (Bi-PAP).

(c) If the facility is billing the complex medical rate for the same individual for the same dates of service.

(6) PRIOR AUTHORIZATION. A nursing facility must obtain prior authorization from the Department prior to admitting an individual into a Ventilator Assisted Program Unit on a form designated by the Department.

(7) DOCUMENTATION- The endorsed nursing facility must maintain sufficient documentation as described in OAR 411-090-0150.

(8) OVERPAYMENT FOR VENTILATOR ASSISTED PROGRAM MEDICAID PAYMENTS. The Department may collect monies that were overpaid to a facility for any period the Department determines the resident's condition or service needs did not meet the criteria for an eligible individual or determines the facility did not maintain the required documentation per OAR 411-090-0150. The Department shall issue an order to the facility that includes the determination described in this paragraph and the facts supporting the determination as well as the amount of overpayment the Department seeks to recoup.

(9) ADMINISTRATIVE REVIEW.

(a) If a provider disagrees with the order of the Department regarding overpayment pursuant to section (8) of this rule, the provider may either request from APD an informal administrative review of the decision or appeal the order as described in this paragraph.

(b) If the provider requests an informal administrative review, the provider must submit its request for review in writing within 30 days of receipt of the notice.

(A) The provider must submit documentation, as requested by APD, to substantiate its position.

(B) APD shall notify the provider in writing of its informal decision within 45 days of APD’s receipt of the provider’s request for review.

(C) APD’s informal decision shall be an order in other than a contested case and subject to review pursuant to ORS chapter 183.

(c) A provider who disagrees with the order issued pursuant to section (8) of this rule may appeal the order pursuant to a contested case proceeding.

The provider must submit an appeal in writing within 60 days of receipt of the notice.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0095 Resident Funds

(Amended 3/1/2008)

(1) Each Medicaid resident is allowed a monthly amount for personal incidental needs. For purposes of this rule, personal incidental funds (PIFs) include monthly payments as allowed and previously accumulated resident savings.

(2) FACILITY RESPONSIBILITY.

(a) The facility must not charge for items included in the bundled rate or for other items or services for which funding can be provided through the Medicaid agency or another non-resident source.

(b) The facility must hold, safeguard and account for a resident's funds if he or she requests such management; or if the case manager requests on Form SDS 0542 that the facility perform such management.

(c) The facility must maintain a record of the request by the resident, case manager or resident representative on Form SDS 0542, covering all funds it holds or manages for residents.

(d) The facility must manage resident funds in a manner in the resident's best interest.

(A) The facility must not charge the resident for holding, disbursing, safeguarding, accounting for, or purchasing from resident funds. Charges for these services are included in the Nursing Facility

Financial Statement, Form SPD 35 or 35A and are considered allowable costs reimbursable through the bundled rate.

(B) The cost for items charged to resident funds must not be more than the actual purchase price charged by an unrelated supplier.

(C) The facility may not charge SPD residents or other sources for items or services furnished if all residents receiving such items or services are not charged. Charges must be for direct, identifiable services or supplies furnished to individual residents. A periodic "flat" charge for routine items, such as beverages, cigarettes, etc., is not allowed. Charges must be made only after services are performed or items are delivered.

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

(E) The nursing facility may request technical assistance from SPD/Type B AAA staff, however, responsibility for managing resident funds in the resident's best interest remains with the facility.

(F) 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 that define those duties.

(G) Facilities holding resident funds must be insured to cover all amounts held in trust.

(3) DELEGATION OF AUTHORITY.

(a) The resident may manage his or her personal financial resources, including PIFs, and may authorize another person or the facility to manage them. If appropriate, the facility must, upon written authorization by the

resident, resident representative, or case manager on the resident’s behalf, accept responsibility for holding, safeguarding, spending and accounting of the resident’s funds.

(b) At the time of admission, the facility must assure that the resident, or representative delegating such responsibility to the facility, completes Form SDS 0542, Designation of Management of Personal Incidental Funds. The facility must sign the form acknowledging responsibility. The facility must retain the original in the resident's account records, with copies to the resident and SPD.

(c) The resident wishing to change delegation must do so by completing a new Form SDS 0542 that must be available at the facility.

(d) SPD cannot be delegated to account for the resident's funds.

(4) RESIDENT ADMISSION.

(a) The facility must provide each resident or resident representative with a written statement at the time of admission that:

(A) States the facility's responsibility to pay for all services, supplies and facility equipment required for services (basic rate);

(B) Lists all services provided by the facility that are not included in the facility's basic rate;

(C) States that there is no obligation for the resident to deposit funds with the facility;

(D) Describes the resident's right to select how personal funds will be handled. The following alternatives must be included:

(i) The resident's right to receive, retain, and manage his or her personal funds or have this done by a legal guardian, or conservator;

(ii) The resident's right to delegate on the SDS 0542 another person to act for the purpose of managing his or her personal funds; and

(iii) The facility's obligation, upon written authorization by the resident or representative, to hold, safeguard and account for the resident's personal funds in accordance with these rules;

(E) States that any facility charge for this service is included in the facility's basic rate, and that the facility cannot charge for resident fund management or charge residents more than the actual purchase price of items at an unrelated supplier;

(F) States that the facility is permitted to accept a resident's funds to hold, safeguard and account for, only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee; and

(G) States that if the resident becomes incapable of managing his or her personal funds and does not have a representative, the facility is required to manage his or her personal funds if requested on the Form SDS 0542 by the case manager.

(b) The facility must obtain documentation on the Form SDS 0542 of:

(A) Resident intention to manage own funds; or

(B) Resident, resident representative, or case manager delegation to another individual or the facility to manage the resident’s funds.

(5) RESIDENT ACCOUNT RECORDS.

(a) The facility must maintain a Resident Account Record (Form SDS 713), on an ongoing, day-to-day basis, for each resident for whom the facility is holding funds. Each receipt or disbursement of funds must be posted to the resident's account. Posting from supporting documentation must be done within seven days after the transaction date.

(b) The resident account record must 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 must provide a list showing description and price of items purchased, along with payment receipts for these items.

(c) Individual resident accounts must be reconciled and listed by the facility at the end of each calendar month.

(d) Petty cash accounts must be reconciled within ten days of receipt of the bank statement.

(e) The facility must maintain a monthly list that separately lists the petty cash and savings account balances for each resident for whom the facility is managing funds.

(f) Records and supporting documentation must be retained for at least three years following the death or discharge of the resident.

(g) Accumulations of $50 or more.

(A) The facility must, within 15 days of receipt of the money, deposit in an individual interest-bearing account any funds held in excess of $50 for an individual resident, unless this money is being managed in a Trust and Agency Account by SPD.

(B) The account must be individual to the resident, must be in a form that clearly indicates that the facility does not have an ownership interest in the funds, and must be insured under federal or state law.

(h) Accumulations of Under $50.

(A) The facility may accumulate no more than $50 of a resident's funds in a pooled bank account or petty cash fund that must be separate from facility funds.

(B) The interest earned on any pooled interest-bearing account containing residents' petty cash must be either prorated to each resident on an actual interest-earned basis, or prorated to each resident on the basis of his or her end-of-quarter balance.

(6) RESIDENT RIGHTS.

(a) The resident must be allowed to manage his or her own funds, or to delegate their management to another, unless the resident has been determined to be incompetent by a court of law. A resident who was not adjudicated incompetent may always decide how to spend his or her own funds.

(b) Facility staff delegated to manage resident funds must follow guidelines outlined in this rule and other state and federal laws and regulations that may apply in order to assure that decisions not made by the resident are made in his or her best interest.

(c) The resident, family or friends has the right to be free from solicitation from the facility to purchase items that are included in the facilities daily rate.

(d) The resident must not be charged for any item included in the facility's daily rate unless the facility can show at least one of the following:

(A) The resident made an informed decision to purchase the item, understanding that a similar and appropriate item is included in the daily rate;

(B) The family requested that the facility purchase the item, understanding that a similar and appropriate item is included in the daily rate; or

(C) The resident is not currently able to make an informed decision to purchase the item, but did so prior to current incapacity.

(e) The resident, family or friends must not be charged for any drug designated by the Food and Drug Administration as less-than-effective unless it can show that both the physician and the resident made an informed decision to continue use of the drug.

(f) Prior to purchasing an item that is included in the facility's daily rate or is over $50, the facility must consult with the SPD/Type B AAA case manager.

(g) The facility must not charge resident funds for any item or service that benefits the facility, facility staff or relatives or friends of facility staff, unless it can show that the resident made an informed decision to purchase the item or service.

(h) When the facility or SPD is of the opinion that a resident is incapable of managing personal funds and the resident has no representative, the facility must refer the resident to the case manager in the local SPD/Type B AAA, who will consult with the resident regarding resident preference. If the attending physician agrees, as documented on the Form SDS 544, Physician's Statement of Resident's Capacity to Manage Funds, that the resident is incapable of handling funds, the case manager will attempt to find a suitable delegate to manage the resident's funds. If no delegate can be found, the facility must assume the responsibility. If the resident

disagrees with the designation of a delegate, the designation cannot be made, and the resident retains the right to manage, delegate, and direct use of his own money, if not adjudicated incompetent.

(7) ACCESS TO FUNDS, RECORDS.

(a) The facility must provide each resident or delegate reasonable access to his or her own financial records and funds. Reasonable access is defined as seven business days for records and one business day for funds.

(b) The facility must provide a written statement, at least quarterly, to each resident, delegate, or a person chosen by the resident to receive the statement. The quarterly statement must reflect separately all of the resident's funds that the facility has deposited in an interest-bearing account plus the resident funds held by the facility in a petty cash account or other account. The statement must include at least the following:

(A) Identification number and location of any account in which that resident's personal funds have been deposited;

(B) Balances at the beginning of the statement period;

(C) Total deposits with source and withdrawals with identification;

(D) Interest earned, if any;

(E) Ending balances; and

(F) Reconciliation.

(c) The facility must provide a quarterly Resident Account Record on Form SDS 713 to the local SPD/Type B AAA within 15 days following the end of the calendar quarter and provide a copy to the resident or an individual delegated by the resident to receive the copy.

(d) The resident or delegate must have access to funds in accordance with OAR 411-085-0350.

(e) Within ten business days of the resident's transfer or discharge, or appointment of a new delegate as documented on the Form SDS 0542, the facility must provide a final accounting and return to the resident, or the delegate, all of the resident's funds that the facility has received for holding, safeguarding, and accounting, and that are maintained in a petty cash fund or individual account.

(8) CHANGE OF OWNERSHIP.

(a) The facility must give each resident or delegate a written accounting of any personal funds held by the facility before any transfer of facility ownership occurs, with a copy to the local SPD/Type B AAA.

(b) The facility must provide the new owner and the local SPD/Type B AAA with a written accounting of all resident funds being transferred and must obtain a written receipt for those funds from the new owner.

(9) LOCAL SPD/TYPE B AAA RESPONSIBILITY. The local SPD/Type B AAA must:

(a) Monitor receipt of SDS 713 forms and review them quarterly for appropriateness of expenditures;

(b) Monitor resident resources for resources over the current Medicaid limit;

(c) For residents incapable of managing their own funds and having no one to delegate to do so, attempt to determine resident wishes, seek physician input on the physician statement, and find a delegate, delegating the facility if necessary and not in conflict with resident wishes;

(d) Notify the facility of inappropriate expenditures and report uncorrected problems to SPD Central Office and assist residents in obtaining legal counsel; and

(e) Track expensive or reusable items purchased for residents through resident funds or by SPD and assure their appropriate use after resident death.

(10) DEATH OF RESIDENT.

(a) Within five business days following a resident's death, the facility must send a written accounting of the resident's funds to the executor or administrator of the resident's estate. If a deceased resident has no executor or administrator, the facility must provide the accounting to:

(A) The resident's next of kin;

(B) The resident's representative;

(C) The clerk of probate court of the county in which the resident died; and

(D) Estate Administration Unit, Seniors and People with Disabilities, P.O. Box 14021, Salem, OR 97309-5024.

(b) Within five business days following a resident's death, the facility must:

(A) Send a written accounting of the resident's funds and a listing of resident personal property, including wheelchairs, television sets, walkers, jewelry, etc., to the local SPD Estate Administration Unit;

(B) Hold personal property for 90 days, unless otherwise instructed by the SPD Estate Administration Unit; and

(C) Comply with the laws of Oregon regarding disbursal of resident funds, and any advance payments, or contact the Estate Administration Unit, SPD, for more detailed instructions.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0100 Audit of Personal Incidental Funds

(Amended 2/1/2006)

(1) Records Available to Department. All account records and expenditure receipts for the resident's personal incidental funds must be available in the facility for audit and inspection by representatives of the Department of Human Services.

(2) Department Audits. Audits of a provider's cost reports, financial records and other pertinent documents may be made by the Department to verify that the provider is complying with Federal regulations and State Administrative Rules regarding protection of residents' funds. Copies of the provider's records may be removed from the facility.

(3) Discrepancies. Any discrepancies in the utilization of personal incidental funds brought to the attention of the case manager will be discussed with the facility. If the discrepancy cannot be resolved, the Department will assist the resident in finding an attorney to represent them or bring the situation to the attention of the local district attorney.

(4) Abuse of Funds. Abuse of resident's personal incidental funds or failure to comply with SPD personal incidental funds policy will be considered by the Department in deciding if a provider's agreement will be continued or renewed.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0105 Resident Property Records

(Amended 2/1/2006)

(1) Current Records. The facility must maintain a current, written record for each resident that includes written receipts for all personal possessions deposited with the facility.

(2) Availability. The property record must be available to the resident and the resident's representative.

(3) Personal Property. The resident's private property must be clearly marked with his or her name.

(4) Department Audit. These records are subject to the same audit criteria as all personal incidental funds in OAR 411-070-0100.

(5) Removal from Facility. The Department may remove copies of these records from the facility.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0110 Temporary Absence from Facility (Bedhold)

(Amended 12/1/2009)

(1) SPD does not pay for holding a resident's bed when the individual is absent from the facility.

(2) Personal incidental funds or payment from an individual's family may be used to hold a facility bed if there are no vacancies in the facility to which other residents of the same sex may be admitted and if there is no duplicate payment from SPD. Personal incidental funds may only be used if the resident so chooses.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0115 Transfer of Residents

(Amended 2/1/2006)

(1) Prior Approval Required. A resident must not be transferred to another facility without prior approval by the resident, the attending physician, branch worker, and the facility's director of nursing services. Reassignment of rooms within the facility requires prior notice to the case manager. All transfers, both inter- and intra-facility, must be conducted in accordance with resident's rights as described in OAR chapter 411, division 085 and the transfer rules in OAR chapter 411, division 088.

(2) Emergency Transfer. In an emergency, consultation with the branch worker is waived. However, the branch worker must be notified by the facility of the resident's transfer at the earliest possible opportunity.

(3) Noncompliance. Failure on the part of the facility administration to comply with this rule can constitute a basis for withholding payment for care of the resident involved.

Statutory/Other Authority: ORS 410.070, 414.065, 441.357
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0120 Discharge of Residents

(Amended 2/1/2006)

When the attending physician indicates that the resident does not, or in the future will not, require long-term care, facility authorities must report this fact to the branch office no later than the first branch office working day following the physician's notification. Upon request, the branch office will assist the resident, facility, relatives, or guardian in developing plans and arrangements for discharge placement. Resident's refusal to be discharged will relieve the Department of responsibility for payment.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0125 Medicare, (Title XVIII)

(Amended 12/1/2009)

SPD shall pay on behalf of eligible individuals the coinsurance rate established under Medicare, Part A, Hospital Care, for care rendered from the 21st day through the 100th day of care in a Medicare certified nursing facility. SPD shall pay the appropriate rate as described in these rules for care beyond the 100th day. Payment shall be subject to documentation required for the rate.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0130 Medicaid Payment in Hospitals

(Amended 07/12/2024)

(1) SWING BED ELIGIBILITY. To be eligible to receive a Medicaid payment under this rule, a hospital must:

(a) Have approval from the Centers for Medicare and Medicaid Services (CMS) to furnish skilled nursing facility services as a Medicare swing-bed hospital;

(b) Have a Medicare provider agreement for acute care; and

(c) Have a current signed Health Services Division (HSD) provider agreement to receive Medicaid payment for swing-bed services.

(2) SERVICES PROVIDED. The daily Medicaid rate shall be for the services outlined in OAR 411-070-0085 (Bundled Rate).

(3) COMPLIANCE WITH MEDICAID REQUIREMENTS. Hospitals receiving Medicaid payment for swing-bed services must comply with state and federal rules and

statutes that affect long-term care facilities as outlined in the facility's provider agreement with HSD.

(4) ADMISSION OF MEDICAID ELIGIBLE INDIVIDUALS TO INTERMEDIATE CARE FACILITY (ICF). Prior to determination of Medicaid eligibility in the ICF swing bed, the APD case manager must coordinate with the hospital for continued Medicaid services and payment.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0140 Hospice Services

(Amended 10/1/2013)

(1) CONTRACT.

(a) The Department enters into a contract (provider agreement) to reimburse Medicare certified hospice providers in Oregon for services provided in Medicaid certified nursing facilities under the following conditions:

(A) The Medicare-certified hospice provider must have a written contract with the nursing facility; and

(B) A copy of the completed contract must be made available to the Department upon request.

(b) The hospice provider must have a completed, written contract (provider agreement) with the Department for nursing facility-based hospice services prior to being determined eligible for reimbursement.

(2) REIMBURSEMENT.

(a) The Department pays the hospice provider a rate equal to 100 percent of the rate that the nursing facility would otherwise receive.

(b) The hospice provider is solely responsible for reimbursing the nursing facility.

(c) Reimbursement for services provided under this rule is available only if the recipient of such services is Medicaid-eligible, Medicare hospice eligible, and been found to need nursing facility services through the Pre-Admission Screening process.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

Nursing Facilities/Medicaid – Reimbursement

411-070-0300 Filing of Financial Statement

(Amended 4/1/2014)

(1) The provider must file annually with the Department, Financial Audit Unit, the Nursing Facility Financial Statement (NFFS) covering actual costs based on the facility's fiscal reporting period for the period ending June 30. A NFFS must be filed for other than a year only when necessitated by termination of a provider agreement with the Department, or by a change in ownership, or when directed by the Department. Financial reports containing up to 15 months of financial data are accepted for the reasons above or with the Department's permission prior to filing.

(2) A NFFS is due on or before October 31 or within three months of a change of ownership or withdrawal from the program.

(a) A NFFS must be postmarked on or before the due date to be considered timely. An extension may not be obtained.

(b) A penalty is assessed and collected when a NFFS is not postmarked within the due date. The amount of the penalty is $5 per licensed nursing facility bed per day for each State of Oregon business day the NFFS is late.

The total penalty may not exceed $50,000 per fiscal reporting period. For purposes of this section, the number of licensed nursing facility beds is the number of beds licensed on the last day of the fiscal reporting period that the facility failed to submit a NFFS.

(c) The Department may assess interim penalties and deduct the amount of the interim penalties from the next Medicaid payment payable to the facility. Each interim penalty is the amount of the penalty that has accrued under subsection (2)(b) of this section to the date of assessment, and has not already been assessed as an interim penalty.

(d) A facility may request an informal conference or contested case hearing pursuant to ORS 183.413 through 183.470 within 30 days of receiving a letter from the Department informing the facility of assessment of an interim penalty or a penalty under this rule. OAR 411-070-0435 applies to such requests and sets forth the procedures to be followed. If no request for an informal conference or contested case hearing is made within 30 days of receiving such a letter, the interim penalty or penalty becomes final in all respects, including liability for payment of and the amount of the interim penalty or penalty.

(3) An improperly completed or incomplete NFFS is returned to the facility for proper completion.

(4) FORMS.

(a) Form SPD 35 is a uniform cost report to be used by all nursing facility providers, except those that are hospital based.

(b) Form SPD 35A is a uniform cost report to be used by all nursing facility providers that are hospital based.

(c) Forms SPD 35 and SPD 35A must be completed in accordance with the Medicaid Nursing Facility Services Provider Guide and Audit Manual.

(5) If a provider knowingly or with reason to know files a NFFS containing false information, such action constitutes cause for termination of its agreement with the Department. Providers filing false reports may be referred for prosecution under applicable statutes.

(6) Each required NFFS must be signed by a company or corporate officer or a person designated by the corporate officers to sign. If a NFFS is prepared by someone other than an employee of the provider, the individual preparing the NFFS must also sign and indicate his or her status with the provider.

(7) Facilities with fewer than 1000 Medicaid resident days during a twelve-month reporting period or fewer than 2.74 Medicaid resident days per calendar day, for facilities with reporting periods of less than a year, are not required to submit a SPD 35 or SPD 35A but must submit a letter to the Department indicating the nursing facility is not submitting a NFFS. This letter is due the same day a NFFS would have been due.

(8) A NFFS must be filed annually by each facility for the fiscal reporting period that ends June 30. The NFFS filed for the period that ends June 30 is required to cover actual costs during the previous state fiscal year from July 1 through June 30.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, Or Laws 2013 ch 608

411-070-0302 Filing of Revised Financial Statements

(Amended 2/1/2006)

(1) Revised Nursing Facility Financial Statements may only be filed with prior written authorization from the Department.

(2) An amended report must be postmarked within six months of the end of the fiscal reporting period.

Statutory/Other Authority: ORS 414.070
Statutes/Other Implemented: ORS 410.070

411-070-0305 Accounting and Record Keeping

(Amended 2/1/2006)

(1) Nursing Facility Financial Statements are to be prepared in conformance with generally accepted accounting principles and the provisions of these rules. The Department has the option to prescribe and interpret these rules in conformance with generally accepted accounting principles.

(2) Financial Statements must be filed using the accrual method of accounting except governmental facilities using the cash method of accounting may file reports using the cash method.

(3) The provider must maintain, for a period of not less than three years following the date of submission of the Nursing Facility Financial Statement, financial and statistical records that are accurate and in sufficient detail to substantiate the cost data reported. If there are unresolved audit questions at the end of this three-year period, the records must be maintained until the questions are resolved. The records must be maintained in a condition that can be audited for compliance with generally accepted accounting principles and provisions of these rules.

(4) Expenses reported as allowable costs must be adequately documented in the financial records of the provider or they will be disallowed.

(5) The Department will maintain each required Nursing Facility Financial Statement submitted by a provider for three years following the date of submission of the report. In the event there are unresolved audit questions at

the end of this three year period, the statements will be maintained until such questions are resolved.

(6) The records of the provider must be available for review by authorized personnel of the Department and of the U.S. Department of Health and Human Services during normal business hours at a location in the State of Oregon specified by the provider.

(7) Accrued expenses that are forgiven by a creditor will be considered as income to the facility and offset against expenses in the subsequent period. Accruals that are settled at less than full value will have the forgiven amount considered as income and offset against expenses.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0310 Auditing

(Amended 2/1/2006)

(1) All Nursing Facility Financial Statements are subject to desk review and analysis within six months after proper completion and filing.

(2) The desk review will determine, to the extent possible:

(a) That the provider has properly included its costs on the Nursing Facility Financial Statement in accordance with generally accepted accounting principles and the provisions of these rules; and

(b) That the provider has properly applied the cost finding method specified by the Department to its allowable costs determined in subsection (2)(a) of this rule; and

(c) Whether further auditing of the provider's financial and statistical records is needed.

(3) All filed Nursing Facility Financial Statements are subject to a field audit, normally to be completed within one year from the date of filing.

(4) The field audit will, at a minimum, be sufficiently comprehensive to verify that in all material respects:

(a) Generally accepted accounting principles and the provisions of these rules have been adhered to; and

(b) Reported data are in agreement with supporting records; and

(c) The Nursing Facility Financial Statement is reconcilable to the appropriate IRS report and payroll tax reports.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0315 Maximum Allowable Compensation of Administrator and Assistant Administrator

(Amended 2/1/2006)

(1) The maximum compensation of a full-time (40 hours per week) licensed administrator to a nursing facility may be allowable at the lower of compensation actually received or the maximum allowable administrator compensation amount determined annually using the calculation in section (4) of this rule.

(2) The maximum compensation of not more than one full-time (40 hours per week) assistant administrator to a nursing facility with at least 80 licensed beds may be allowable at the lower of compensation actually received or seventy-five percent of the allowable administrator compensation for the number of licensed beds in the nursing facility. The Department will not allow the cost of an assistant administrator in a facility with less than 80 beds.

(3) If either of the above individuals works less than 40 hours in the average week, allowable compensation must be the lower of actual compensation received or the maximum allowable administrator compensation determined annually based on the calculation in section (4) of this rule, multiplied by the percentage of 40 hours worked in the average week. The provider must maintain adequate records to demonstrate time actually spent.

(4) The maximum allowable administrator compensation may be adjusted each year and will be effective as of January 1 each year. The rates must be established using the gross allowable compensation in Account 411 (Administrator Compensation) of the Nursing Facility Financial Statement for non-owner administrators. The applicable compensation amounts will be inflated by the U.S. CPI from the mid point of each facility's fiscal year to July 1. The 75th percentile of each bed-size category, 1-49, 50-79, 80-99, 100 and over, will be the ceiling for each grouping.

(5) When a single individual serves as the administrator of both a nursing facility and a hospital, the salary will be pro-rated to both functions. The nursing facility portion will then be compared to the pro-rated share of the allowable administrator compensation to determine the amount to be included as allowable.

Statutory/Other Authority: ORS 414.070
Statutes/Other Implemented: ORS 410.070

411-070-0320 Consultants

(Amended 7/1/1997)

(1) Costs for direct care and dietitian consultant services to the staff of the facility will be allowed.

(2) No other consultant costs will be allowed.

(3) Payment for treatment and evaluation provided directly to an individual resident by medical providers will not be paid by Seniors and People with Disabilities Division.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0330 Owner Compensation

(Amended 2/1/2006)

(1) Reasonable compensation for services performed by owners (whether sole proprietors, partners, or stockholders) is an allowable cost, provided the services are actually performed, documented, and are necessary, and the provisions of this rule are met.

(2) The allowance of compensation for services of sole proprietors and partners is the amount determined by the Department to be the reasonable value of the services rendered as long as compensation was paid in conformance with this rule.

(3) Compensation for services performed by owners may be included in allowable provider cost only to the extent that it represents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the facility and rendered in connection with resident care. Services rendered in connection with resident care include both direct and indirect activities in the provision and supervision of resident care, such as administration, management, and overall supervision of the institution. Services which are not related to either direct or indirect resident care; e.g., those primarily for the purpose of managing or improving the owner's financial investment are not recognized as an allowable cost. Costs related to the owner's management and overall supervision of the facility will be reported in Account 436.

(4) Payments to an owner that represent a return on equity capital are not allowable costs for reimbursement purposes. Such payments are not considered as compensation for purposes of determining the reasonable level of reimbursement of the owner.

(5) The compensation allowance will be an amount as would ordinarily be paid for comparable services in other nursing facilities, as defined by section (6) of this rule. This determination will be made by the Department depending upon the facts and circumstances of each case.

(6) For purposes of determining whether the compensation paid to or claimed by an owner is reasonable, the total of all benefits and remuneration such as travel allowance or key-man insurance, regardless of the form, will be considered. The Department has established the 75th percentile ranking of average compensation paid, in all facilities by job category, as being reasonable.

(7) Accrued compensation of an owner, if not paid within 75 days after the end of the Nursing Facility Financial Statement reporting period, may not be included as an allowable expense.

(8) An owner must not be compensated for services in excess of 40 hours in one week. This rule applies even if an owner may provide services in more than one area.

(9) The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the institution.

(10) Compensation paid to an employee who is an immediate relative of the owner of the facility is also reviewable under the test of reasonableness. For this purpose, the following persons are considered "immediate relatives": Husband and wife; natural parent, child and sibling; adopted child and adoptive parent;

stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; and grandparent and grandchild, uncle, aunt, nephew, niece, and cousin.

(11) Where an owner provides services for more than one facility or is engaged in other occupations or business activities, allowable compensation may be adjusted to reflect an appropriate allocation of time spent in each area based on the combined total of resident days.

(12) Where an owner functions as an administrator or assistant administrator, the rules governing compensation of these positions apply, in addition to the requirements of this rule.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070

411-070-0335 Related Party Transactions

(Amended 2/1/2006)

(1) Costs applicable to services and supplies furnished to a provider by organizations related to the provider by common ownership or control are allowable at the lower of cost excluding profits and markups to the related party or charge to the facility. Such costs are allowable to the extent that they relate to resident care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. Documentation of costs to related parties (including those identified in OAR 411-070-0330(10)) must be made available at time of audit. If documentation is not available, such payments to or for the benefit of the related organization will be non-allowable costs.

(2) An exception is provided to the general rule in section (1) of this rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the Department:

(a) That the supplying organization is a separate legal entity; and

(b) That a substantial part of the supplying organization's business activity, of the type carried on with the provider, is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. Prices paid by the provider may not be in excess of what would be paid by a prudent cost conscious buyer.

(3) If the provider takes the position that an exception as stated in section (2) of this rule applies, then the provider must:

(a) Make available the books and records of the related organization to SPD auditors; and

(b) Maintain a receiving report signed by personnel of the nursing facility for services or supplies furnished by the related organization.

(4) Rental expense paid to related organizations for facilities may be allowable to the extent the rental does not exceed the related organization's costs of owning (e.g., depreciation, interest on a mortgage) or leasing the assets, computed in accordance with the provisions of these rules. The exception listed in section (2) of this rule does not apply to rental expense paid for facilities.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0340 Chain Operations

(Amended 2/1/2006)

(1) A chain organization consists of a group of two or more health care facilities that are owned, leased, or through any other device controlled by one business entity. This includes not only proprietary chains but also chains operated by various religious and other charitable organizations.

(2) Although the home office of a chain is normally not a provider in itself, it may furnish to the individual provider central administration or other service such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual cost of providing such services is includable in the provider's allowable costs under the program.

(3) Home office costs that are not otherwise allowable costs when incurred directly by the provider are not allowable as home office costs to be allocated to providers. Where the home office is a mere holding company and provides no services related to resident care, no costs of the home office are allowable to the providers in the chain or single facility.

(4) Where an owner receives compensation from the home office for services to the facility, the compensation is allowable only to the extent that it is related to resident care and to the extent that it is reasonable as defined under owner's compensation.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0345 Allocation of Home Office and Regional Office Costs

(Amended 2/1/2006)

(1) The initial step in the allocation of home office and regional office costs is direct allocation of all allowable costs directly attributable to a particular nursing facility (such as construction interest, salary where the administrator of a nursing facility in the chain is paid directly by the home office, etc.) or non-nursing facility activity.

(2) Other allowable costs must appropriately be allocated among the providers (and to any non-provider activities in which the home office or regional office may be engaged) on the basis of beds, resident days, or other bases, whichever most equitably allocates such costs. Revenues are not generally appropriate for

distributing these costs. Where possible, allocation of costs are to be based on function and, consequently, the bases of allocation may appropriately be different, say for accounting costs and for personnel costs. Where the home office or regional office incurs costs for activities not related to resident care in the chain's participating providers, the allocation basis must provide for all allocation of costs such as rent, administrative salaries, other general overhead costs, organization costs, etc., that are attributable to non-resident care as well as resident care activities.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0350 Management Fees

(Amended 12/1/2009)

Management fees are an allowable expense if they are necessary, reasonable, non-duplicative of facility personnel and functions, and documented by a binding contract with a non-related party defining the items, services, and activities provided. If the administrator or assistant administrator is supplied as part of the contract, the rules governing their compensation in these rules apply. Documentation demonstrating that the services were actually performed is required. Management fees paid to a related organization are subject to the rules governing related parties (OAR 411-070-0335), chain operations (OAR 411-070-0340), and allocation of home office costs (OAR 411-070-0345). The allowable salary paid to the administrator and assistant administrator is included in the total facility management fee calculation. Total management fees for allowable management and supervisory services may not exceed the limits established for the administrator and the assistant administrator in OAR 411-070-0315 plus $5,000 allowable for other management fees per year.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0359 Allowable Costs

(Amended 12/1/2020)

(1) ALLOWABLE COSTS. Allowable costs are the necessary costs incurred for the customary and normal operation of a facility, to the extent that they are reasonable and related to resident services.

(a) Accounting, Auditing, and Data Processing -- The costs of recording, summarizing, and reporting the results of operations are allowable.

(b) Advertising -- Help wanted advertising and the expense related to the alphabetical listing in the yellow pages of a phone directory are allowable.

(c) Allowable Workers Compensation Dividends (Refunds) or Billings of the nursing facility are those dated in the fiscal reporting period.

(d) Auto and Travel Expense -- Expense of maintenance and operation of a vehicle and travel expense related to resident services are reimbursable. The allowance for mileage reimbursement must not exceed the amount determined reasonable by the Internal Revenue Service for the period reported. Allowable out-of-state travel is restricted to Washington, Idaho, and Northern California, no farther south than San Francisco. One out of state/contiguous area trip per year for two employees shall be allowed, as long as it relates to resident services.

(e) Bad Debts -- Bad debts related to Title XIX recipients are allowable.

(f) Bank and Finance Charges -- Charges for routine maintenance of accounts are allowable.

(g) Communications -- Charges for routine telephone service, including pagers, and cable television fees, are allowable.

(h) Compensation of Owners -- Owner's compensation in accordance with OAR 411-070-0330 is allowable.

(i) Consultant Fees -- Consultant fees are allowable provided they meet the criteria as outlined in OAR 411-070-0320.

(j) COVID-19 -- Costs of COVID-19 related expenses not reimbursed by the State of Oregon or the federal government are allowable. The Emergency Health Care Center (EHCC) revenue is non-allowable.

(k) Criminal Records Checks -- Costs of criminal records checks of facility employees if mandated by federal or state law are allowable.

(l) Depreciation and Amortization -- Depreciation schedules on buildings and equipment must be maintained. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Depreciation and amortization must be calculated on a straight-line basis and prorated over the estimated useful life of the asset. Effective July 1, 2003, these costs must be reported in accordance with OAR 411-070-0365, OAR 411-070-0375, and OAR 411-070-0385.

(m) Education and Training -- Registration, tuition, and book expense associated with education and training of personnel is allowed provided it is related to resident services. The costs associated with training and certifying nurse aides are not allowable for inclusion in the annual NFFS. These costs are reimbursed separately by SPD per OAR 411-070-0470.

(n) Employee Benefits -- Employee benefits that are made available to all employees, are for the primary use of the employees, are generally considered by the industry as reasonable and important benefits to provide for employees, are not taxable as wages, and are allowable to the extent of employer participation.

(o) Food -- Food products and supplements used in food preparation are allowable.

(p) Home Office Costs -- Home office costs are allowable in accordance with OAR 411-070-0345.

(q) Insurance -- Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to resident services. Self-insurance costs are allowable only when expense is actually incurred.

(r) Interest -- Interest on debt related to the provision of resident services is an allowable expense, except on or after July 1, 1984, interest expense related to that portion of the acquisition price of a long-term facility that exceeds the depreciable basis (OAR 411-070-0375) will not be reimbursable.

(s) Legal Fees -- Legal fees directly related to resident services are allowable. Legal fees related to non-allowable costs are not allowable. Legal fees claimed as related to resident services must be explained and listed on Schedule A. Fees related to legal and administrative actions to resolve a disagreement with the state shall be allowable if the action is resolved in the provider's favor, and the judge or hearings officer does not order the state to pay the provider's legal fees.

(t) Licenses, Dues, and Subscriptions -- Fees for facility licenses, dues in professional associations, and costs of subscriptions for newspapers, magazines, and periodicals provided for resident and staff professional use are allowable.

(u) Linen and Bedding -- Linen and bedding costs for the facility are allowable.

(v) Management Fees -- Management fees are allowable provided they meet the criteria for OAR 411-070-0350.

(w) Postage and Freight -- Postage expense is considered an office supply cost. Freight must be posted to the same account as the item purchased.

(x) Property Costs -- Costs related to purchase or lease of a facility are to be reported in Accounts 452 through 459 and 461.

(y) Purchased Services -- Services that are received under contract arrangements are reimbursable to the extent that they are related to resident services and the sound conduct and operation of the facility.

(z) Rent or Lease Payments -- Payments for the lease or rental of land, buildings, and equipment are to be reported. Payments for lease agreements entered into with a related party are limited to the lower of actual costs or the lease payments.

(aa) Repairs and Maintenance -- Costs of maintenance and minor repairs are allowable when related to the provision of resident services.

(bb) Salaries (Except Owners and Related Parties) -- Salaries and wages of all employees engaged in resident service activities or overall operation and maintenance of the facility, including support activities of home offices and regional offices, are allowable.

(cc) Supplies -- Cost of supplies used in resident services or providing services related to resident services are allowable.

(dd) Taxes -- Property taxes on assets used in rendering resident services are allowable. Long term facility taxes paid on resident days are allowable, effective July 1, 2003.

(ee) Utilities -- Costs for facility heating, lighting, water-sewer, and garbage provisions are allowable.

(ff) Utilization Review -- Costs incurred for utilization review are Medicare related and are not allowable for Medicaid reimbursement.

(2) EXCEPTIONS. Exceptions to the items listed in section (1) of this rule must be approved in writing to be allowable. Exceptions shall not be granted for the following items:

(a) Amortization of non-competitive agreement;

(b) Goodwill;

(c) Federal and other governmental income taxes;

(d) Penalties and fines;

(e) Costs of services and items otherwise reimbursable through DMAP, other third party payors (see section (3) of this rule), or the resident's personal funds;

(f) The cost related to the functioning of Corporate Boards of Directors;

(g) Advertising for purposes of soliciting potential residents, except for listings in the yellow pages (see section (1)(b) of this rule);

(h) The cost of salaries and supplies devoted to religious activities; or

(i) Gifts and contributions.

(3) THIRD PARTY PAYORS. The purpose of this section is to assure that facilities are not paid twice, once through the Medicaid bundled rate and again through a third party payor, for providing a service. This section includes both allowed and non-allowed costs.

(a) Facilities must bill third party payors for nursing facility services whenever payment from a third party payor is or may be available. Examples of such payors are Medicare, Veterans Administration, insurance companies, or a private resident when the items are not included in the basic rate.

(b) Failure to bill or collect from third party payors whenever appropriate may not cause these expenses to be considered allowable.

(c) The cost of services incurred for therapy services performed by non-employee therapists are reimbursable through a third party payor or DMAP and are non-allowable on the NFFS.

(d) The cost of supplies and equipment medically necessary in the performance of therapy services that are reimbursable through a third party payor or DMAP, are non-allowable on the NFFS.

Statutory/Other Authority: ORS 410.070, 414.065
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0365 Capital Assets

(Amended 2/1/2006)

(1) The following costs must be capitalized and depreciated: Expenses for depreciable assets with historical cost in excess of $1,000 per unit, or in aggregate, and a useful life greater than one year from the date of purchase.

(2) Repair costs in excess of $1,000 on equipment or buildings must be capitalized.

(3) The provider must maintain schedules of capital assets and depreciation, on a straight line basis, to document amounts on the Nursing Facility Financial Statement.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0370 Depreciable Assets

(Amended 2/1/2006)

(1) Tangible assets of the following types in which a provider has an economic interest through ownership are subject to depreciation:

(a) Buildings -- The basic structure or shell and additions thereto;

(b) Building Fixed Equipment -- Attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, and air conditioning system. The general characteristics of this equipment are:

(A) Affixed to the building and not subject to transfer;

(B) A fairly long life but shorter than the life of the building to which affixed.

(c) Movable Equipment -- Such items as beds, wheelchairs, desks, vehicles, and other depreciable items. The general characteristics of these equipment are:

(A) Capable of being moved;

(B) Subject to control and meeting the definition of a capital asset.

(d) Land Improvements -- Such items as paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. where replacement is the responsibility of the provider;

(e) Leasehold Improvements -- Betterments and additions made by the lessee to the leased property that become the property of the lessor after the expiration of the lease.

(2) Land is not Depreciable. The cost of land includes the cost of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, and the cost of curbs and side walks, replacement of which is not the responsibility of the provider.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0375 Depreciation Basis

(Amended 2/1/2006)

(1) Purchase of a Nursing Home:

(a) New Facility -- The depreciation basis of a new facility must be the historical cost of building the facility, including preparation for use, or the purchase price from an unrelated organization not to exceed the fair market value, including preparation for use, less salvage value;

(b) Ongoing Facility -- The depreciation basis of the purchase of an ongoing facility from an unrelated organization is limited to the lower of the following:

(A) The allowable acquisition cost of such asset to the first owner of record on or after July 18, 1984; or

(B) The acquisition cost of such asset to the new owner.

(c) To properly provide for costs or valuations of fixed assets, an appraisal by an appraisal expert will be required if the provider has no historical cost records, or has incomplete records of depreciable fixed assets, or purchases a facility without designation of purchase price for the classification of assets acquired. The appraisal is subject to the approval of

the Department. In any case, the Department may require such an appraisal to establish the fair market value of the provider assets;

(d) If the purchase is from a related organization, the cost basis is the lower of the cost basis of the related organization or the cost basis as determined in subsections (b) and (c) of this section, less depreciation as determined by the provisions of these rules.

(2) The depreciation basis of other assets must be the historical cost to the provider from an unrelated organization plus set-up costs, less salvage value. In the case of a trade-in, the historical cost will consist of the sum of the book value of the trade-in plus the cash paid. In a case where the asset is purchased from a related organization, the depreciation basis must not exceed the asset's book value to the related organization as determined under the provisions of this guide.

(3) The depreciation basis of donated assets, defined as an asset acquired without making any payment for it in the form of cash, property, or services, must be the lessor of:

(a) Fair market value at the date of donation adequately documented in the provider's records or by appraisal by an appraisal expert, less salvage value; or

(b) If from a related organization, the depreciation basis must be the lesser of:

(A) Fair market value; or

(B) The depreciation basis the related party had or would have had for the asset under the program.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0385 Depreciation Lives

(Amended 2/1/2006)

(1) The provider must use the "Estimated Useful Lives of Depreciable Hospital Assets" Revised 2004 guidelines for asset lives when computing depreciation.

(2) For assets not covered by the guidelines and with costs of more than $1,000 per unit, or in aggregate, the lives established by the provider are subject to approval by the Department.

(3) Depreciation and amortization schedules must be maintained.

(4) Depreciation expense is not allowed on land.

(5) Depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0400 Equity

(Amended 2/1/2006)

Equity is not an allowable expense for reimbursement but must be reported. Equity capital is the net worth of the provider (owner's equity in the net assets as determined under these rules), adjusted for those assets and liabilities that are not related to the provision of resident care:

(1) Generally accepted accounting principles are to be used unless otherwise specified in these rules for computing owner's equity.

(2) Assets and liabilities not related to providing resident care are not includable in the provider's equity capital.

(3) Loans from owners or related entities are considered as invested equity capital of the provider.

(4) Owner's equity in assets leased from related entities is includable in the equity capital of a proprietary provider.

(5) Goodwill is not includable as part of owner's equity.

(6) Invested funds that are diverted to income producing activities that are not resident related for more than six months will not be included as part of owner's equity.

(7) Amounts deposited in a funded depreciation account and the earnings on deposits are not included in equity capital. Interest earned on these funds is not offset against interest expense.

(8) Land, buildings, and other assets acquired in anticipation of expansion are not includable in equity capital. Construction-in-process and liabilities related to such construction are not includable in equity capital.

(9) Prepaid premiums on life insurance carried by a provider on officers and key employees, where the provider is designated as the beneficiary, are not included when computing equity capital.

(10) The costs of noncompetitive agreements are not includable in equity capital.

(11) The amount deposited and the earnings on self-insurance reserve funds are not includable in equity capital.

(12) When an asset is totally or partially destroyed by a casualty, the unrecovered loss is not included in equity capital.

(13) Working capital, defined as the difference between current assets and current liabilities, must be adjusted by any amount considered to be excessive

for the necessary and proper operation of resident care activities. The excessive amount will not be included in equity capital.

(14) The cash surrender value of insurance is not includable in equity capital.

(15) Imputed salaries for proprietors will be offset in computing the equity capital.

(16) Any portion of an acquisition cost, incurred on or after July 18, 1984, that exceeds the depreciable basis is not includable in the owner's equity calculation.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0415 Offset Income

(Amended 12/1/2009)

(1) Income is offset against expenses unless specifically excluded in section (2) of this rule. If an adjustment is for a revenue producing activity representing a non-allowable cost, the revenue must be offset against the appropriate expense if the revenue is less than 2 percent of the total provider expense (sum of cost areas). Where the revenue is greater than 2 percent of the total provider expense (sum of cost areas), costs must be allocated to this area as described in OAR 411-070-0430, Allocation Methods.

(2) Income items that may not be offset are:

(a) Ancillary income and charges for routine services or supplies that are included in the bundled rate but charged to other residents (except as required in OAR 411-070-0359(3));

(b) Grants, unless designated for paying a specific operating cost; and

(c) Donations, unless designated for paying a specific operating cost.

(3) Revenue received for pediatric residents shall be offset against expenses. These revenues may not be subject to the 2 percent limitation established in section (1) of this rule. The revenue shall be offset against cost centers in the same ratio as reported by the facility in accordance with OAR 411-070-0452.

(4) Mental health revenues received from local governments to provide extra care to Medicaid residents must be reported in SPD Account 819, directly offset against the related expense and explained on Schedule A.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0417 Treatment of Complex Medical Add-Ons

(Amended 12/1/2009)

(1) The complex medical add-on reflects the additional costs of providing skilled nursing services for certain residents due to their needs.

(2) The complex medical add-on is added to the basic rate.

(3) When calculating per resident day care compensation cost, the treatment of the complex medical add-on is as follows:

(a) The allowable care compensation costs for both the basic rate and the complex medical add-on are divided by total basic rate resident days.

(b) Revenue from the complex medical add-on received for eligible individuals is divided by the number of Medicaid basic rate resident days.

(c) The per resident day amounts computed in section (3)(a) of this rule are reduced by the per Medicaid resident day amounts computed in section (3)(b) of this rule. The result is defined as care compensation per resident day and shall be used in determining the prospective base rate.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0420 Base Year Cost Finding

(Amended 2/1/2006)

(1) The provider must report its gross costs and must make reclassifications and adjustments to costs as provided in these rules. This process will determine net allowable costs on the Nursing Facility Financial Statement that includes a uniform chart of accounts provided by the Department. The gross costs and revenues must agree with the statement of earnings and expenses or profit and loss statement of the provider. Revenues are to be reported in the same manner as costs on the Nursing Facility Financial Statement. The provider must also use the balance sheet provided to report its gross assets, gross liabilities, and gross equity, make reclassifications and adjustments as provided by these rules.

(2) The per diem costs of care must be used to determine each provider's allowable per diem costs and must be effective for the same period as covered by the Nursing Facility Financial Statement.

(3) The per diem costs of each facility will be used to establish the basic rate on July 1 of each odd numbered year.

(4) Costs, revenues, assets, liabilities, and owner's equity attributable from a home office or regional office to a provider under OAR 411-070-0345 will be included on the Nursing Facility Financial Statement in the Home Office column. The home office financial data must be reconcilable to the home office financial statements and records.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, 414.065

411-070-0425 Resident Days

(Amended 2/1/2006)

The provider must keep census records on all residents.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0428 Cost Center Expenses

(Repealed 3/1/2008)

411-070-0430 Allocation Methods

(Amended 2/1/2019)

(1) The provider must use the allocation methods designated on the NFFS: COST -- ALLOCATION METHOD:

(a) Property -- Resident Days or Square Footage.

(b) Administrative and General -- Resident Days.

(c) Other Operating Support -- Resident Days.

(d) Food -- Resident Days.

(e) Direct Care Compensation -- Actual Cost or Resident Days.

(f) Direct Care Supplies -- Actual Cost or Resident Days.

(g) Ventilator Assisted Program Expense -- Actual Cost or Resident Days.

(2) Where costs are related to non-nursing facility activities, the provider must use an appropriate allocation method to reasonably and accurately allocate these costs (see OAR 411-070-0415). For residential care facility individuals, the facility must use resident days for all areas except direct care compensation and direct care supplies and property. The direct care compensation and direct care

supplies allocation must be actual costs incurred. The property allocation method may be based on either resident days or on square footage and must be designated on the NFFS.

(3) Square footage must be used to allocate property costs to pediatric units as defined in OAR 411-070-0452.

(4) Actual payroll for the pediatric unit must be used as the basis for allocating direct care compensation to pediatric units.

(5) If APD determines that for a provider it is more reasonable and accurate to use a different allocation method than specified in sections (1) and (2) of this rule, then such allocation method must be used.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0435 Appeals

(Amended 2/1/2006)

(1) The Department will send letters to a provider that inform the provider of any changes made by the Department from the provider Nursing Facility Financial Statement. A provider is entitled to an informal conference or a contested case hearing pursuant to ORS 183.413 -183.470, as described in sections (2) or (3) of this rule, to protest the change(s).

(2) The provider may request an informal conference, by notifying the Department in writing within 30 days of receipt of the letter from the Department that informs the provider of the change(s). The request for an informal conference must be postmarked within the 30-day limit and must state, specifically, the reason(s) for requesting the conference. At the informal conference, the provider may submit documentation and explain the basis for the provider's protest. Following the informal conference, the Department will

notify the provider of its decision by mail. No judicial review is available following a decision from an informal conference. If the provider is not satisfied with the decision, the provider may request a contested case hearing pursuant to ORS 183.413-183.470 by notifying the Department in writing of the request for the hearing within 10 working days of the date of the decision letter from the informal conference. If a provider is not satisfied with the results from the contested case hearing, the provider may petition for judicial review pursuant to ORS 183.480-183.497.

(3) As an alternative to section (2) of this rule, the provider may request a contested case hearing pursuant to ORS 183.413-183.470 by notifying the Department in writing that a contested case hearing is requested within 30 days of receipt of the letter from the Department that informs the provider of the change(s). The request for the contested case hearing must be postmarked within the 30-day limit and must state, specifically, the reason(s) for requesting the hearing. If a provider is not satisfied with the results from the contested case hearing, the provider may petition for judicial review pursuant to ORS 183.480 - 183.497.

(4) If no request for an informal conference or contested case hearing is made within the specified time period, the most recent decision from the Department will automatically become a final order.

(5) A provider may request documentation supporting the change(s) from the Department; however, a request for documentation does not toll the time period within which an informal conference or contested case must be requested. The Department will produce these work papers within 30 days of receipt for a written request.

Statutory/Other Authority: ORS 414.070
Statutes/Other Implemented: ORS 410.070

411-070-0436 Employee Retention Payment Reimbursement Program

(Adopted 04/01/2022)

(1) ESTABLISHMENT. The Department establishes the Employee Retention Payment Reimbursement Program (Program). The Program is designed to promote the availability of nursing home level of care to Oregonians through the current direct-care workforce shortage.

(2) FACILITY ELIGIBILITY. All licensed nursing facilities are eligible for participation in the Program, regardless of whether the facility is enrolled as a Medicaid provider.

(3) VOLUNTARY. Participation in this program is highly encouraged by the Department but is not mandatory.

(4) EMPLOYEE. For the purposes of this Program, an employee includes any employee whose regular worksite is at the location of the facility, regardless of whether the employee is part-time or full-time, hourly or salaried. Employee does not include contracted staff.

(5) The Department will provide a one-time reimbursement to facilities that have issued a retention payment of $500 or more per employee and have properly submitted an approved claim form in the timeline provided. The maximum reimbursement will be $500 per employee, regardless of whether the facility has paid a higher retention payment, incurred additional administrative expenses, or incurred additional payroll-related expenses.

(6) The reimbursement payment will be limited to employees who were employed continuously by the nursing facility from October 8, 2021 through November 15, 2021. The payment, from the nursing facility, will be provided to eligible employees after November 15, 2021, to ensure employees continued to be employed during the duration of the Program period.

(7) CLAIM FORM. In order to receive reimbursement, nursing facilities must submit one claim form for the Program on a form adopted by the Department. The Department's form will require the nursing facility to attest that all onsite employees were paid a minimum $500 retention payment, regardless of job classification.

(8) TIMELINESS. Forms for the Employee Retention Payment Reimbursement Program must be submitted to the Department no earlier than December 1, 2021, and no later than December 31, 2021 in order to be eligible for reimbursement. Nursing facilities may only submit one claim form for reimbursement.

(9) AUDIT. The Department may conduct audits and require verification of payment to qualifying employees at its discretion.

(10) OVERPAYMENT. Nursing facilities are liable for refunding any overpayments to the Department.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0437 Quality and Efficiency Incentive Program

(Amended 09/28/2016)

(1) ESTABLISHMENT. Effective October 7, 2013 through June 30, 2016, the Department establishes the Quality and Efficiency Incentive Program (Program) in order to implement Enrolled House Bill 2216 (Chapter 608, 2013 Oregon Laws) and Enrolled Senate Bill 1585 (2016). The Program is designed to reimburse quality nursing facilities that voluntarily reduce bed capacity that increases occupancy levels and enhances efficiency with the goal of slowing the growth of system-wide costs. The Department may provide additional compensation to nursing facilities who qualify for the legislatively approved Program. Such compensation may not exceed $9.75 per resident day and may not exceed four

years from the date of eligibility. Eligibility to participate in this Program sunsets on June 30, 2016.

(2) CAPACITY REDUCTION DISCUSSIONS. If two or more providers wish to initiate discussions concerning reduction of bed capacity in a community, the providers must notify the Department. The notice must identify the community and state that the parties wish to discuss reduction of bed capacity in that market pursuant to the Program.

(a) Upon receipt of a notice to discuss reduction of bed capacity, the Department shall review the notice and either approve or disapprove the proposed preliminary discussion. The Department shall approve the preliminary discussion if the community is one in which the proposed capacity reduction is consistent with the goals of the Program.

(b) If the Department approves the preliminary discussion, the Department shall notify the providers who requested approval and shall schedule a meeting at which a Department representative shall be made available to supervise the discussion. Providers in the affected market may attend the meeting and may discuss capacity reduction for that market under the supervision of the Department.

(c) The Department shall determine the time, place, and mechanism to discuss the reduction of bed capacity. The discussions may be held in-person or by means of conference call, video conference, or such other means that allow for each participant to hear and be heard by the other participant at the same time.

(d) Notice to the Department is not required for two providers who wish to discuss a specific transfer of bed capacity.

(3) CAPACITY REDUCTION TRANSACTIONS. Prior to any purchase of bed capacity under the Program, the parties to the transaction must notify the Department.

(a) The notice must describe the parties, the specific facilities, the proposed transaction, and the acquisition plan for the transaction.

(b) The acquisition plan must include documentation demonstrating that:

(A) The purchasing operator is able to meet or arrange for the needs of the individuals residing in the selling facility and meet all change of ownership or operator and closure criteria as described in OAR 411-085-0025;

(B) The selling operator meets the eligibility criteria described in section (5) of this rule and meets the criteria for nursing facility closure described in OAR 411-085-0025;

(C) Bed capacity in the community shall be reduced as a result of the transaction; and

(D) The transaction does not compromise care or health status of residents.

(c) The Department may approve the acquisition plan, disapprove the acquisition plan, or request further information or changes in the acquisition plan. The Department shall approve the transaction upon finding that the acquisition plan is expected to satisfy conditions (A) through (D) in subsection (b) of this section. If the Department approves or disapproves the transaction, the Department shall issue an order approving or disapproving the transaction and explaining how conditions (A) through (D) in subsection (b) of this section are satisfied or not satisfied.

(d) The purchasing operator may receive incentives under the Program only if the Department approves the transaction and the purchasing and selling operators complete the transaction as described in the acquisition plan. Upon meeting the qualifying conditions, eligibility for the incentives

will be effective on the date the operator submitted the acquisition plan to the Department. The purchasing operator and selling operator are entitled to state action antitrust immunity for the transaction only if the Department approves the transaction.

(e) Once approved for participation in the Program, the selling facility must provide all notices and meet the other requirements of a facility closure under OAR 411-085-0025, including limiting admissions of residents to the facility.

(4) COMMUNITY TRANSITION MEETING.

(a) The Department, in consultation with the Long Term Care Ombudsman, shall convene a regional planning meeting in communities in which a facility plans to surrender the facility's license under these rules. The meeting shall engage the community in:

(A) Planning to promote the safety and dignity of residents who shall be impacted by the surrender;

(B) A discussion regarding the local need for more home and community-based settings; and

(C) Assessing opportunities for more residential programs and supporting residential capacity.

(b) The Community Transition Meeting is initiated by the Department upon approval of an acquisition as described in this rule.

(5) ELIGIBILITY. The eligibility requirements for participation in the Program are:

(a) The nursing facility bed capacity being sold (the "selling facility") is not an Essential Nursing Facility or from a facility operated on behalf of the Oregon Department of Veteran’s Affairs; and

(b) The selling facility's entire bed capacity is purchased and the seller agrees to surrender the nursing facility's license on the earlier of the date that:

(A) The last resident is transferred from the facility; or

(B) 180 days after the effective date of the sale of the facility bed capacity.

(c) A Program applicant (the "purchasing operator") must meet all of the following criteria at the time of the acquisition plan submission:

(A) Operate one or more facilities licensed by the Department as a nursing facility;

(B) Must be determined to be in substantial compliance from the annual licensing and recertification survey at the date of the acquisition plan submission; and

(C) Have no substantiated facility abuse meeting the criteria in ORS 441.715(2)(c) within six months of the date of the acquisition plan submission.

(d) The selling facility must provide all notices and meet the requirements of a facility closure under OAR 411-085-0025.

(6) ANTITRUST PROVISION.

(a) The Department declares its intent to exempt from state antitrust laws and provide state action immunity from federal antitrust laws individuals and entities that engage in transactions, meetings, or surveys described in sections (2) and (3) of this rule that might otherwise be constrained by such laws.

(b) The following activities are not immunized from antitrust liability:

(A) Agreements among competing providers to reduce the number of beds they operate outside of a sale;

(B) Provider meetings to discuss bed reduction strategies outside of the negotiation of a specific sale and where no Department representative is in attendance; or

(C) Collateral agreements between competing providers that involve their pricing strategies, how to respond to requests for proposals, or other discussions outside the sale of facilities.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, Or Laws 2013 ch 608

411-070-0438 Enhanced Wage Add-on Program

(Adopted 03/03/2022)

(1) ESTABLISHMENT. The Department establishes the Enhanced Wage Add-on Program (Program). The Program is designed to support nursing facilities with retention of Certified Nursing Assistants (CNAs) by paying a starting wage of $17 per hour for all Certified Nursing Assistants (CNAs), with an increase to $17.50 per hour by the second year of the 2021-2023 biennium (July 1, 2022).

(2) The Department will provide additional compensation to nursing facilities who meet the criteria contained in paragraph (3). Such compensation shall be an add-on of 4% of the daily Medicaid nursing facility rate during the effective dates of the Program. A nursing facility may be eligible to apply between October 1, 2021 and June 30, 2023.

(3) CRITERIA. Criteria must be met in order for a nursing facility to be eligible for the Enhanced Wage Add-on Program. The nursing facility shall submit documentation supporting that it provides a starting wage of $17 per hour or more for all CNAs, escalating up to $17.50 per hour or more by the second year

of the 2021-2023 biennium (July 1, 2022). Sufficient documentation shall be submitted to the Department with the required form referenced in paragraph (5) and shall include at least one of the following:

(a) A copy of a collective bargaining agreement or addendums with such provisions;

(b) Amended policies that includes the wages for CNAs during the period of the Program;

(c) Notification to CNAs of wages during the period of the Program; or

(d) Payroll records demonstrating rates of pay for CNAs equal to or higher than $17.50 per hour.

(e) Written communication to staff with wage criteria that includes reference to the Legislature establishing a wage add-on to Medicaid rates for the purpose of supporting caregiver wages in partnership with the Oregon Department of Human Services, the Oregon Health Care Association, SEIU Local 503, and other senior care advocates.

(4) PAYMENT. The Department will provide the Enhanced Wage Add-on equal to 4% of the daily Medicaid nursing facility rate between October 1, 2021 and June 30, 2023, for nursing facilities who meet the criteria contained in paragraph (3). The documentation of the criteria being met shall be submitted with the form by the 15th of the month for which the provider is requesting to be approved. The wage add-on rate will not be effective until the Department provides written approval to the nursing facility.

(5) FORM. Nursing facilities shall submit a claim for the Enhanced Wage Add-on Program on the form created by the Department. The documentation of the criteria being met shall be submitted with the form by the 15th of the month for which the provider is requesting to be approved.

(6) APPLICABILITY. The Department will only provide the Enhanced Wage Add-on rate for services provided during the period of October 1, 2021, to June 30, 2023, in which the facility was in compliance with the criteria contained in paragraph (3).

(7) TIMELINESS. Forms for the Enhanced Wage Add-on rate may be submitted during the effective dates of the Program. The documentation of the criteria being met shall be submitted with the form by the 15th of the month for which the provider is requesting to be approved.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0439 COVID-19 Emergency Response Incentive Program

(Adopted 12/1/2020)

(1) ESTABLISHMENT. The Department establishes the COVID Response Incentive Program (Program). The Program is designed to support nursing facilities in adopting employment policies that protect employees during the COVID-19 pandemic.

(2) The Department will provide additional compensation to nursing facilities who meet the criteria contained in paragraph (3). Such compensation shall be 2.5% of their Medicaid Resident Revenue for services provided during the effective dates of the Program. A facility may be eligible for any continuous 90-day period between May 1, 2020 and September 30, 2020.

(3) CRITERIA. All three of the following criteria must be met in order for a nursing facility to be eligible for the incentive payment.

(a) Increased paid time off: The nursing facility must demonstrate that it increased paid time off for workers who become sick with COVID-19 or for individuals who are being asked to quarantine by their employer or

medical professional or who are waiting for test results. Employees receiving paid time off due to COVID-19 illness must receive pay equal to their regular hourly compensation for scheduled work shifts. Sufficient evidence must be submitted with the required claim form referenced in paragraph (5) and may include:

(A) For facilities with collective bargaining agreements, a copy of any collective bargaining agreements or addendums with such provisions if changes were made;

(B) A letter to all staff stating that this protection has been granted;

(C) Amended staff policies or handbooks; or

(D) Copies of payroll records showing paid time off for ill employees.

(b) Employee Retention: The nursing facility must demonstrate that it did not terminate or discipline the employment of any employee who notified their employer that they were taking leave because:

(A) They had, or were suspected to have, COVID-19;

(B) A family member had, or was suspected to have COVID-19; or

(C) They have been asked to quarantine by their employer or medical professional or are waiting for test results.

(c) Enhanced Compensation: The nursing facility shall submit documentation that it provided enhanced compensation for frontline caregivers who were at risk of exposure to COVID-19 due to an exposure or confirmed case of COVID-19 in the nursing facility where they worked. The documentation shall be submitted on the claim form referenced in paragraph (5) and may include:

(A) A copy of a collective bargaining agreement or addendums with such provisions;

(B) Amended policies or handbook that includes a definition of who is a “frontline caregiver at risk of exposure to COVID-19”;

(C) Notification to staff of increased compensation due to COVID-19 risk or exposure; or

(D) Payroll records demonstrating enhanced payments for COVID-19 exposure risk.

(4) PAYMENT. The Department of Human Services will provide an incentive payment equal to 2.5% of Medicaid resident revenue for services provided between May 1, 2020 and September 30, 2020, for nursing facilities who meet all of the criteria contained in paragraph (3). A facility may be eligible for any continuous 90-day period between May 1, 2020 and September 30, 2020.

(5) CLAIM. Nursing facilities shall submit a claim for the incentive payment on the form mandated by the Department of Human Services.

(6) APPLICABILITY. The Department will only provide the incentive payment for services provided during the time period May 1, 2020 to September 30, 2020, in which the facility was in compliance with the criteria contained in paragraph (3) and for a continuous 90-day period only.

(7) TIMELINESS. Claims for the incentive payment may be submitted no earlier than October 1, 2020 and no later than December 31, 2020. Nursing facilities may submit one claim form and one supplemental claim for Medicaid resident revenues not previously submitted on the initial claim form.

Statutory/Other Authority: 410.070
Statutes/Other Implemented: 410.070

411-070-0442 Calculation of the Basic Rate, Complex Medical Rate, Bariatric Rate and Ventilator Assisted Program Rate

(Amended 08/26/2022)

(1) The rates are determined annually and referred to as the Rebasing Year.

(a) The basic rate is based on the statements received by the Department by October 31 for the fiscal reporting period ending on June 30 of the previous year. For example, for the year beginning July 1, 2018, statements for the period ending June 30, 2017 are used. The Department desk reviews or field audits these statements and determines the allowable costs for each nursing facility. The costs include both direct and indirect costs. The costs and days relating to pediatric beds and Ventilator Assisted Program beds are excluded from this calculation. The Department only uses financial reports of facilities that have been in operation for at least 180 days and are in operation as of June 30.

(b) For each facility, its allowable costs, less the costs of its self-contained pediatric unit (if any), or the Ventilator Assisted Program Unit, are inflated by the DRI Index, or its successor index. The DRI table as published in the fourth quarter of the year immediately preceding the beginning of the payment year will be used. Costs will be inflated to reflect projected changes in the DRI Index from the mid-point of the fiscal reporting period to the mid-point of the payment year (e.g., for the July 1, 2018 rebase, the midpoint of the fiscal reporting period is December 31, 2016 and the mid-point of the payment year is December 31, 2018).

(c) For each facility, its allowable costs per Medicaid day is determined using the allowable costs as inflated and resident days, excluding pediatric and ventilator days as reported in the statement.

(d) The facilities are ranked from highest to lowest by the facility's allowable costs, per Medicaid day.

(e) The basic rate is determined by ranking the allowable costs per Medicaid day by facility and identifying the allowable cost per day at the applicable percentage. If there is no allowable cost per day at the applicable percentage, the basic rate is determined by interpolating the difference between the allowable costs per day that are just above and just below the applicable percentage to arrive at a basic rate at the applicable percentage. The applicable percentage for the period beginning July 1, 2018 is at the 62nd percentile.

(2) Due to the COVID-19 pandemic, a temporary 10% increase to the basic rate has been authorized for nursing facilities for services provided April 1, 2020 thru June 30, 2020.

(3) Due to the extraordinary expenses incurred as a result of the COVID-19 pandemic, a 5% increase to the basic rate has been authorized for nursing facilities for services provided January 1, 2021 thru June 30, 2023.

(4) The Department provides an augmented rate to nursing facilities who qualify under the Quality and Efficiency Incentive Program as described in OAR 411-070-0437. An acquisition plan must be submitted to the Department on or after October 7, 2013 and on or before June 30, 2016. The purchasing operator must meet all requirements in OAR 411-070-0437(3) in order to receive the augmented rate. The qualifying nursing facility is paid the augmented rate for each Medicaid-eligible resident.

(5) Nursing facility bed capacity in Oregon shall be reduced by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veteran’s Affairs and facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December

1, 2012, or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013. An official bed count measurement shall be determined and issued by the Department as of July 1, 2016 and each quarter thereafter if the goal of reducing the nursing facility bed capacity in Oregon by 1,500 beds is not achieved.

(a) For the period beginning July 1, 2013 and ending June 30, 2016, the Department shall reimburse costs as set forth in section (1) of this rule at the 63rd percentile.

(b) For each three-month period beginning on or after July 1, 2016 and ending June 30, 2018, in which the reduction in bed capacity in licensed facilities is less than the goal described in this section, the Department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:

(A) 63rd percentile for a reduction of 1,500 or more beds.

(B) 62nd percentile for a reduction of 1,350 or more beds but less than 1,500 beds.

(C) 61st percentile for a reduction of 1,200 or more beds but less than 1,350 beds.

(D) 60th percentile for a reduction of 1,050 or more beds but less than 1,200 beds.

(E) 59th percentile for a reduction of 900 or more beds but less than 1,050 beds.

(F) 58th percentile for a reduction of 750 or more beds but less than 900 beds.

(G) 57th percentile for a reduction of 600 or more beds but less than 750 beds.

(H) 56th percentile for a reduction of 450 or more beds but less than 600 beds.

(I) 55th percentile for a reduction of 300 or more beds but less than 450 beds.

(J) 54th percentile for a reduction of 150 or more beds but less than 300 beds.

(K) 53rd percentile for a reduction of 1 to 149 beds.

(c) For the period beginning July 1, 2018 and ending June 30, 2026, the Department shall reimburse costs, as set forth in section (1) of this rule, at the 62nd percentile.

(6) The complex medical rate is 140% percent of the basic rate.

(7) The Ventilator Assisted Program rate is 235% of the established basic rate.

(8) The bariatric rate is 185% of the established basic rate.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, OL 2003 ch. 736, OL 2007 ch. 780, OL 2009 ch. 827, OL 2011 ch. 630, OL 2013 ch. 608, OL 2018 ch. 66

411-070-0452 Pediatric Nursing Facilities

(Amended 08/26/2022)

(1) PEDIATRIC NURSING FACILITY.

(a) A pediatric nursing facility is a licensed nursing facility at least 50 percent of whose residents entered the facility before the age of 14 and all of whose residents are under the age of 21.

(b) A nursing facility that meets the criteria of subsection (1)(a) of this section is reimbursed as follows:

(A) The pediatric rate is a prospective rate and is not subject to settlement. The Department uses financial reports of facilities that have been in operation for at least 180 days and are in operation as of June 30.

(B) The facility specific pediatric cost per resident day is inflated as described in OAR 411-070-0442(1)(b). The Oregon Medicaid pediatric days are multiplied by the inflated facility specific cost per resident day for each pediatric facility. The totals are summed and divided by total Oregon Medicaid days to establish the weighted average cost per pediatric resident day. The rebase relationship percentage of 93 percent is applied to the weighted average cost to determine the pediatric rate.

(c) Due to the COVID-19 pandemic, a temporary 10% increase to the pediatric rate has been authorized for nursing facilities for services provided April 1, 2020 thru June 30, 2020.

(d) Due to the extraordinary expenses incurred as a result of the COVID-19 pandemic, a 5% increase to the pediatric rate has been authorized for nursing facilities for services provided January 1, 2021 thru June 30, 2023.

(e) Even though pediatric facilities are reimbursed in accordance with subsection (1)(b) of this section, pediatric facilities must comply with all requirements relating to the timely submission of Nursing Facility Financial Statements.

(2) LICENSED NURSING FACILITY WITH A SELF-CONTAINED PEDIATRIC UNIT.

(a) A nursing facility with a self-contained pediatric unit is a licensed nursing facility that provides services for pediatric residents (individuals under the age of 21) in a separate and distinct unit within or attached to the facility with staffing costs separate and distinct from the rest of the nursing facility. All space within the pediatric unit must be used primarily for purposes related to the services of pediatric residents and alternate uses may not interfere with the primary use.

(b) A nursing facility that meets the criteria of subsection (2)(a) of this section is reimbursed for pediatric residents served in the pediatric unit as described in section (1) of this rule.

(c) Licensed nursing facilities with a self-contained pediatric unit must comply with all requirements relating to the timely submission of Nursing Facility Financial Statements and must file a separate attachment, on forms prescribed by the Department, related to the costs of the self-contained pediatric unit.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070, OL 2011 ch. 630, OL 2013 ch. 608

411-070-0462 Long-Term Care Upper Limit

(Repealed 3/1/2008)

411-070-0464 Final Report

(Amended 2/1/2006)

(1) FINAL REPORTS. When a provider agreement is terminated for any reason, the provider must submit final reports in accordance with OAR 411-070-0300. Full payment for the month during which the provider agreement is terminated will not be made by the Department until final reports are received and desk reviewed. The Department will initially pay the provider the excess by which the payment for the month in which the provider agreement is terminated exceeds

the maximum amount the Department can penalize a provider under OAR 411-070-0300(2)(c). The remainder of the payment must be made by the Department after receipt and desk review of final reports.

(2) Settlement rates based on Nursing Facility Financial Statements submitted for the period that ends June 30, 1997 must be calculated as defined by these rules as they existed on June 30, 1997.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0465 Uniform Chart of Accounts

(Amended 12/1/2020)

The following account definitions will be used to classify the dollar amounts on the Nursing Facility Financial Statement (NFFS). The account balance is to be reported in whole dollars under the facility gross column on the NFFS and referenced by the providers' chart of accounts number. It is the provider's responsibility to ensure that the balances reported reconcile to their fiscal year statements and general ledger balances with any differences explained on Schedule A to Form SPD 35 or SPD 35A. The provider is responsible for making adjustments to these accounts for non-allowable items and amounts using the adjustment column to arrive at the net allowable balance. Each adjustment is to be explained on Schedule A to Form SPD 35 or SPD 35A.

(1) CURRENT ASSETS -- The following accounts include cash and other assets reasonably expected to be realized in cash or sold, or consumed during the normal nursing facility operating cycle, or within one year when the operating cycle is less than one year.

(a) 101 -- Cash on Hand -- This account balance represents the amount of cash on hand for petty cash funds.

(b) 102 -- Cash in Bank -- This account balance represents the amount in a bank checking account.

(c) 103 -- Cash in Savings -- This account balance represents the amount accumulated in a savings account.

(d) 104 -- Resident Trust Account -- This account balance represents the amount of resident funds entrusted to the provider and held as cash on hand in the bank.

(e) 109 -- Accounts Receivable -- This account balance represents the amounts due from or due on behalf of all residents at the end of the fiscal period being reported.

(f) 110 -- Notes Receivable -- This account balance represents the current balance of amounts owed to the facility (payee) that are covered by a written promise to pay at a specified time, and is signed and dated by the maker.

(g) 111 -- Allowance for Doubtful Accounts -- This account balance represents amounts owed to the facility and estimated to be uncollectible.

(h) 115 -- Employee Advances -- This account balance represents amounts paid in advance to employees for salaries or wages that will be liquidated in the next payroll cycle following the closing date of the financial statement.

(i) 120 -- Inventory -- This account balance represents the cost value of inventory on hand at the end of the reporting period.

(j) 125 -- Prepaid Expenses -- This account balance represents the cost value of paid expenses not yet incurred covering regularly recurring costs of operation like rent, interest, and insurance.

(k) 149 -- Other Current Assets -- This account balance comprises all current assets not identified above. Each item in this account, including short-term savings certificates, must be explained on Schedule A to Form SPD 35 or SPD 35A.

(2) NON-CURRENT ASSETS -- The balances of the following accounts represent assets not recognized as current.

(a) 151 -- Land -- This account balance represents the acquisition cost and other costs, like legal fees and excavation costs that are incurred to put the land in condition for its intended use.

(b) 153 -- Building(s) -- This account balance represents the acquisition cost of permanent structures and property owned by the provider used to house residents. It includes the purchase or contract price of all permanent buildings and fixed equipment attached to and forming a permanent part of the building(s).

(c) 154 -- Accumulated Depreciation -- This account balance represents the accumulation of provisions made to record the expiration in the building(s) life attributable to wear and tear through use, lapse of time, obsolescence, inadequacy or other physical or functional cause. The straight line method is the only recognized depreciation method for cost reimbursement.

(d) 155 -- Land Improvements -- This account balance represents the acquisition cost of permanent improvements, other than buildings that add value to the land. It includes the purchase or contract price.

(e) 156 -- Accumulated Depreciation -- This account is of the same nature and is used in the same manner as Account 154.

(f) 157 -- Building Improvements -- This account balance represents the acquisition cost of additions or improvements that either add value to or

increase the usefulness of the building(s). It includes the purchase or contract price.

(g) 158 -- Accumulated Depreciation -- This account is of the same nature and is used in the same manner as Account 154.

(h) 161 -- Equipment -- This account balance represents the acquisition cost of tangible property of a permanent nature, other than land, building(s) or improvements, used to carry on the nursing facility operations. It includes the purchase or contract price.

(i) 162 -- Accumulated Depreciation -- This account is of the same nature and is used in the same manner as Account 154.

(j) 165 -- Leasehold Improvements -- This account balance represents the acquisition cost of any long-lived improvements or additions to the property being leased that will belong to the owner (lessor) at the expiration of the lease.

(k) 166 -- Accumulated Amortization -- This account is of the same nature and is used in the same manner as Account 154 except the cost of improvements or additions will be amortized over the lesser of the expected benefit life or the remaining life of the lease.

(l) 181 -- Investments -- This account balance represents the value of assets unrelated to the nursing facility operation. The detail of this account must be explained on Schedule A to Form SPD 35 or SPD 35A.

(m) 187 -- Goodwill -- This account balance represents the value of goodwill identified with the purchase of assets.

(n) 199 -- Other -- Non-Current Assets -- This account balance comprises all non-current assets not identified above. Each item in this account,

including long-term savings certificates, must be explained on Schedule A to Form SPD 35 or SPD 35A.

(3) CURRENT LIABILITIES -- The balances of the following accounts are considered current liabilities.

(a) 201 -- Accounts Payable -- This account balance represents the liabilities for goods and services received but unpaid at the end of the reporting period.

(b) 202 -- Accounts Payable -- Resident Trust Account -- This account balance represents the amount owed to residents for the cash entrusted to the facility in Account 104.

(c) 203 -- Notes Payable -- Other -- This account balance represents the current portion of the amount owed by the facility that is covered by a written promise to pay at a specified time and is signed and dated by the facility (maker).

(d) 204 -- Notes Payable to Owner -- This account balance represents notes payable to the owner(s) and is of the same nature and is used in the same manner as Account 203.

(e) 205 -- Accrued Interest Payable -- This account balance represents the liabilities for interest accrued at the end of the reporting period but not payable until a later date.

(f) 207 -- Other Accrued Payable -- This account is of the same accrual nature and is used in the same manner as Account 205 and is to be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(g) 208 -- Payroll Payable -- This account balance is the accrued payroll, less withheld payroll taxes and other deductions, payable to employees at the end of the reporting period.

(h) 217 -- Payroll Tax Payable -- This account balance is the employer's share of accrued payroll taxes payable at the end of the reporting period.

(i) 218 -- Payroll Deductions Payable -- This account balance is the employee's share of accrued payroll taxes withheld from the employer's gross pay payable at the end of the reporting period.

(j) 219 -- Deferred Income -- This account balance represents the liability for revenue collected in advance.

(k) 229 -- Other Current Liabilities -- This account balance comprises all current liabilities not identified above. The nature and purpose of amounts included in this account must be explained on Schedule A to Form SPD 35 or SPD 35A.

(4) LONG-TERM LIABILITIES -- The balances of the following accounts are considered long-term liabilities.

(a) 231 -- Long-Term Mortgage Payable -- This account balance represents the amount owed by the facility that is secured by a mortgage or other contractual agreement providing for conveyance of property at a future date.

(b) 233 -- Long-Term Notes Payable -- This account is of the same nature and is used in the same manner as Account 203 except the liability extends beyond one year.

(c) 234 -- Long-Term Notes Payable Owner -- This account is of the same nature and is used in the same manner as Account 204 except the liability extends beyond one year.

(d) 249 -- Other Long-Term Liabilities -- This account comprises all long-term liabilities not identified above. The amount and nature of items in this account must be explained on Schedule A to Form SPD 35 or SPD 35A.

(5) NET WORTH -- The balances of the following accounts represent the amount by which the facility's assets exceed its liabilities.

(a) 251 -- Capital Stock -- This account balance represents the amount of cash or property received in exchange for the corporation's capital stock.

(b) 255 -- Retained Earnings -- This account balance represents the amount of capital resulting from retention of corporate earnings.

(c) 261 -- Capital Account -- This account balance represents the book value of the proprietor or partner(s) equity in the facility.

(d) 265 -- Drawing Account -- This account balance represents the owners withdrawals of funds during the reporting period that were not paid as part of the payroll.

(e) 290 -- Net Profit (Loss) -- This account balance is the facility's revenue minus expenses for the reporting period.

(6) RESIDENT REVENUE -- These accounts include room and board revenue and related room and board contractual adjustments including revenue from bed hold days for routine service charges exclusive of ancillary charges. Routine service charges are to be reported in the following accounts:

(a) 301 -- Private Resident -- Complex Medical Needs -- This account includes room and board revenue for complex medical needs routine private resident services including health maintenance organization (HMO) payer source for private residents. These are private pay residents whose medical needs correspond to the Medicaid complex medical needs criteria.

(b) 303 -- Private Resident -- Basic Rate -- This account includes room and board revenue for basic rate routine private resident services including HMO payer source for private residents. These are private pay residents whose medical needs correspond to the Medicaid basic rate needs criteria.

(c) 304 -- Private Resident -- Assisted Living Facilities/Residential Care Facilities -- This account includes room and board revenue for other than private complex medical needs and basic rate, non long-term residents and is to be explained on Schedule A to Form SPD 35 or SPD 35A.

(d) 305 -- Private Resident -- Ventilator Assisted Program -- This account includes room and board revenue for Ventilator Assisted resident services including HMO payer source for private residents. These are private pay residents whose medical needs correspond to the Medicaid ventilator rate needs criteria.

(e) 306 -- Private Resident -- Bariatric -- This account includes room and board revenue for bariatric resident services including HMO payer source for private residents. These are private pay residents whose medical needs correspond to the Medicaid bariatric rate needs criteria.

(f) 309 -- Medicaid Resident -- Bariatric -- This account includes room and board revenue from all sources for Medicaid bariatric residents.

(g) 310 -- Medicaid Resident -- Ventilator Assisted Program -- This account includes room and board revenue from all sources for Ventilator Assisted Program Medicaid residents.

(h) 311 -- Medicaid Resident -- Complex Medical Needs -- This account includes room and board revenue from all sources for complex medical needs Medicaid residents.

(i) 312 -- Medicaid Resident -- Pediatric -- This account includes room and board revenue from all sources for pediatric Medicaid residents.

(j) 313 -- Medicaid Resident -- Basic Rate -- This account includes room and board revenue from all sources for basic rate Medicaid residents.

(k) 314 -- Medicaid -- Assisted Living Facilities/Residential Care Facilities -- This account includes room and board revenue for Medicaid, non long-term resident services from all sources other than NF Payment Categories 1, basic rate, complex medical needs and pediatric and is to be explained on Schedule A to Form SPD 35 or SPD 35A.

(l) 315 -- Medicaid -- HMO -- This account includes room and board revenue from all sources for Medicaid-HMO resident services.

(m) 316 -- Medicaid -- Out of State -- This account includes room and board revenue from all sources for non-Oregon Medicaid resident services.

(n) 318 -- Medicare Resident -- This account includes room and board revenue from all sources for Medicare resident services.

(o) 319 -- Other Governmental Resident -- This account includes room and board revenue from all sources for Veteran Affairs and other governmental program resident services other than Medicaid or Medicare and is to be explained on Schedule A to Form SPD 35 or SPD 35A.

(7) ANCILLARY REVENUE -- These accounts include revenue for professional and non-professional services and supplies not included in section (6) of this rule. Revenue other than that described above must be reported as gross revenue and related expenses to be reported in the appropriate expense accounts. Ancillary service charges and ancillary contractual adjustments are to be reported in the following accounts:

(a) 321 -- Nursing Supplies -- This account includes revenue from the sale of nursing supplies or services.

(b) 322 -- Oxygen -- This account includes revenue from the sale of oxygen (gas) and concentrator supplies.

(c) 323 -- Prescription Drugs -- This account includes revenue from the sale of prescription drugs.

(d) 324 -- Laboratory -- This account includes revenue from laboratory services provided.

(e) 345 -- X-Ray -- This account includes revenue from X-Ray services.

(f) 326 -- Equipment Rental -- This account includes revenue from equipment rental.

(g) 330 -- Physical Therapy -- This account includes revenue from physical therapy services provided.

(h) 331 -- Speech Therapy -- This account includes revenue from speech therapy services.

(i) 332 -- Occupational Therapy -- This account includes revenue from occupational therapy services.

(j) 341 -- Personal Purchases -- This account includes revenue from residents for personal purchases.

(k) 342 -- Barber and Beauty -- This account includes revenue from residents for barber and beautician services.

(l) 345 – Ancillary Revenue – Ventilator Respiratory Therapy – This account includes revenue from Respiratory Therapy services provided.

(m) 349 -- Other Ancillary -- Items and amounts included in this account must be described on Schedule A to Form SPD 35 or SPD 35A.

(n) 398 -- Contractual Adjustments -- This is a revenue offset account and includes all contractual adjustments to resident revenue and ancillary revenue.

(8) OTHER REVENUE -- These accounts include other revenue, exclusive of resident and ancillary revenue. The intent is for revenue to be reported in gross and the related expenses reported in the appropriate expense accounts. Other revenues are classified as follows:

(a) 901 -- Grants -- This account includes revenue amounts received in the reporting period from public and privately funded grants and awards.

(b) 902 -- Donations -- This account includes donations in the form of cash or goods and services received during the reporting period.

(c) 903 -- COVID Provider Relief Revenue -- This account includes all revenue amounts received that are COVID related.

(d) 904 -- EHCC (Emergency Health Care Center) Revenue -- This account is for all EHCC Resident (COVID-19 tested positive patient (TPP)) Revenue- This account is for EHCC TPP revenue received for occupied bed days.

(e) 905 -- Emergency Enhanced Care Center (EHCC) Bed Hold Revenue -- This account is for EHCC Bed Hold Revenues received.

(f) 911 -- Interest -- This account includes revenue from any interest bearing note, bank account, or certificate.

(g) 912 -- Staff & Guest Food Sales -- This account includes revenue from facility food sales to individuals other than residents of the facility.

(h) 913 -- Vending Sales -- This account includes revenue from vending machines or for resale items not reported in Accounts 813 and 351.

(i) 914 -- Television and Telephone Revenue -- This account includes revenue from television and telephone sales to residents of the facility.

(j) 915 -- Independent Senior Housing -- This account includes revenue from any other apartment and continuing care retirement community housing.

(k) 916 – Hospital Revenue – This account includes revenue from hospital operations not related to the nursing facility.

(l) 918 – Nursing Aide Training – This account is for reporting all revenue associated with OAR 411-070-0470, Nursing Assistant Training and Competency.

(m) 919 -- Miscellaneous Other Revenue -- Items and amounts, including revenues for Mental Health revenues received from local governments, and Workers Compensation refunds, included in this account are to be described on Schedule A to Form SPD 35 or SPD 35A.

(9) PROPERTY EXPENSES -- These accounts are for reporting property expenses.

(a) 452 -- Interest -- This account is for reporting all interest expense related to the acquisition of fixed assets, adjusted for historical cost limitations.

(b) 453 -- Rent Building -- This account is for reporting all building rent or lease expenses.

(c) 454 -- Leased Equipment -- This account is for reporting equipment rental and lease expense for all equipment used in the administrative and general and other operating expense categories.

(d) 455 -- Depreciation -- Building -- This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 153.

(e) 456 -- Depreciation -- Land Improvement -- This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 155.

(f) 457 -- Depreciation -- Building Improvement -- This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 157.

(g) 458 -- Depreciation -- Equipment -- This account is for reporting depreciation, for the reporting period, associated with assets capitalized in Account 161.

(h) 459 -- Amortization -- Leasehold Improvement -- This account is for reporting amortization, for the reporting period, associated with assets capitalized in Account 165 and Account 166.

(i) 461 -- Miscellaneous -- Property -- This account is for reporting other property costs, such as amortization of organizational costs, and items of equipment less than $1,000 that are for general use, such as privacy curtains and blinds.

(10) ADMINISTRATIVE AND GENERAL EXPENSES -- These accounts report expenses for administration of the facility and the business office, and items not readily associated with other departments.

(a) 411 -- Compensation -- Administrator -- This account is for reporting all the compensation received by the licensed administrator of the facility. Compensation includes salary, bonuses, auto, moving, travel and all other allowances paid directly or indirectly by the facility.

(b) 412 -- Compensation -- Assistant Administrator -- This account is to be used for reporting all compensation of the individual who is identified as, and has the specific duties of, Assistant Administrator.

(c) 413 -- Compensation -- Bookkeeper -- This account is for reporting all the compensation received by the facility bookkeeper, controller and chief financial officer.

(d) 415 -- Compensation -- Other Administrative -- This account is for reporting all of the compensation received by administrative, clerical, secretarial, accounting, central supply, in-service director and personnel.

(e) 418 -- Purchased Services -- Administrative -- This account is for reporting all non-employee services required in the administrative operations of the facility.

(f) 440 -- Payroll Taxes -- Administrative -- This account is for reporting all of the employer's portion of payroll taxes, including Federal Insurance Contributions Act (FICA) tax, unemployment and other payroll taxes not withheld from the employee's pay for administrative employees.

(g) 441 -- Worker's Compensation -- Administrative -- This account is for reporting the employer's portion of worker's compensation insurance not withheld from the employee's pay for administrative employees.

(h) 442 -- Employee Benefits -- Administrative -- This account is for reporting all employer paid employee benefits. These benefits include group insurance, facility picnics, prizes, gifts, and holiday dinners. Established child care benefits are to be included when they are accounted for separately and do not relate directly to a compensation account for administrative employees.

(i) 443 -- Employee Paid Time Off -- Administrative -- This account is for reporting established vacation, holiday and sick pay programs for administrative employees.

(j) 420 -- Vending Expense -- This account is for reporting expenses of non-medical, non-resident service items sold to the residents and non-residents including items sold through vending machines.

(k) 423 -- Personal Purchase -- This account is for reporting all expenditures for personal items purchased for individual residents.

(l) 425 -- Office Supplies -- This account is for reporting expenses of all office supplies except those chargeable to Account 863. Materials include stationery, postage, printing, bookkeeping supplies, and office supplies.

(m) 426 -- Communications -- This account is for reporting all telephone, internet access, communication, and paging system charges.

(n) 427 -- Travel -- This account is for reporting all transportation costs and mileage reimbursement associated with vehicles used for resident services or resident recreation, exclusive of insurance and depreciation and for reporting all other travel expenses such as lodging and meals for conferences, conventions, workshops, or training sessions.

(o) 429 -- Advertising -- Help Wanted -- This account is for reporting all help wanted advertising expense.

(p) 430 -- Advertising -- Promotional -- This account is for reporting all expenditures of the facility related to promotional advertising including yellow page advertising.

(q) 431 -- Public Relations -- This account is for reporting all expenditures related to public relations.

(r) 432 -- Licenses, Dues & Subscriptions -- This account is for reporting all fees for facility licenses; dues in professional associations; and costs of subscriptions for newspapers, magazines, and periodicals provided for resident and staff use.

(s) 433 -- Accounting & Related Data Processing -- This account is for reporting all accounting, payroll, and other data and report processing expenses.

(t) 435 -- Legal Fees -- This account is for reporting all legal fees and expenses. Legal fees must be reported in conformance with OAR 411-070-0359(1)(t).

(u) 436 -- Management Fees -- This account is for reporting all management fees charged to the facility, including management salaries and benefits at the home office.

(v) 437 -- Insurance -- Liability -- This account is for reporting all liability insurance expenses, including employee dishonesty, Board of Director, and umbrella coverage.

(w) 439 -- Other Interest Expense -- This account is for reporting interest expense not attributable to the purchase of the facility and equipment.

(x) 444 -- Bad Debts -- This account is for reporting the expense recorded from recognizing a certain portion of accounts receivable as uncollectible.

(y) 445 -- Education & Training -- This account is for reporting registration, tuition, materials, and manual costs for training the staff included in the administrative and general expense category.

(z) 446 -- Contributions -- This account is for reporting the expense of any gift or donation.

(aa) 449 -- Miscellaneous -- This account is for reporting general administrative operating expenses not specifically included in other general administrative operating expense accounts. Entries must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(bb) 450 -- Long Term Care Facility Tax, effective 07/01/2003.

(11) OTHER OPERATING SUPPORT EXPENSES -- The following accounts are included in this category.

(a) 511 -- Compensation -- Other Operating Employees -- This account is for reporting all compensation received by employee(s) responsible for providing facility repair and maintenance, dietary, laundry and housekeeping services.

(b) 540 -- Payroll Taxes -- Other Operating -- This account is for reporting all of the employer's portion of payroll taxes, including FICA, unemployment and other payroll taxes not withheld from the employee's pay for other operating employees.

(c) 541 -- Worker's Compensation -- Other Operating -- This account is for reporting the employer's portion of worker's compensation insurance not withheld from the employee's pay for other operating employees.

(d) 542 -- Employee Benefits -- Other Operating -- This account is for reporting all employer paid employee benefits. These benefits include group insurance, facility picnics, prizes, gifts, and holiday dinners. Established child care benefits are to be included when they are accounted for separately and do not relate directly to a compensation account for other operating employees.

(e) 543 -- Employee Paid Time Off -- Other Operating -- This account is for reporting established vacation, holiday and sick pay programs for other operating employees.

(f) 548 -- COVID Other Operating – This account is for the reporting of other operating costs incurred for COVID expenses. This account must be explained in detail on Schedule A.

(g) 551 -- Purchased Services -- Maintenance -- This account is for reporting all non-employee services required in maintenance operations.

(h) 552 -- Purchased Services -- Dietary -- This account is for reporting all non-employee services required in dietary operations including dietary consulting expenses.

(i) 553 -- Purchased Services -- Laundry -- This account is for reporting all non-employee services in laundry operations.

(j) 554 -- Purchased Services -- Housekeeping -- This account is for reporting all non-employee services required in housekeeping operations.

(k) 510 -- Real Estate & Personal Property Taxes -- This account is for reporting real estate and personal property tax expenses for the facility.

(l) 512 -- Insurance -- Property & Auto -- This account is for reporting all insurance expenses other than liability insurance reportable in Account 437, and employee insurance expenses.

(m) 513 -- Cable Television -- This account is for reporting all cable and satellite television expenses.

(n) 514 -- Heat & Electricity -- This account is for reporting all facility heating and lighting expenses.

(o) 515 -- Water, Sewer & Garbage -- This account is for reporting all water, sewer and garbage expenses.

(p) 516 -- Maintenance Supplies & Services -- This account is for reporting all expenses required for building and equipment maintenance and repairs including preventative maintenance and not capitalized.

(q) 526 -- Dietary Supplies -- This account is for reporting the expense of all supplies, dishes and utensils, and non--capitalized equipment utilized within this department, exclusive of food.

(r) 532 -- Linen and Bedding -- This account is for reporting the expense of all linen and bedding utilized within the facility.

(s) 536 -- Laundry Supplies -- This account is for reporting the expense of all supplies utilized by the laundry.

(t) 546 -- Housekeeping Supplies -- This account is for reporting the expense of all supplies utilized to provide housekeeping services.

(u) 549 -- Miscellaneous -- Other Operating -- This account is for reporting other operating support expenses not specifically included in an identified account. Entries must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(12) FOOD -- 522 Food -- This account is for reporting all food products and supplements used in food preparations including dietary supplements.

(13) DIRECT CARE COMPENSATION -- These accounts include compensation used in providing direct resident services.

(a) 640 -- Payroll Taxes -- Direct Care -- This account is for reporting the employer's entire portion of payroll taxes, including FICA, unemployment and other payroll taxes not withheld from the employee's pay for direct care employees.

(b) 641 -- Worker's Compensation -- Direct Care -- This account is for reporting the employer's portion of worker's compensation insurance not withheld from the employee's pay for direct care employees.

(c) 642 -- Employee Benefits -- Direct Care -- This account is for reporting all employer paid employee benefits. These benefits include group insurance, facility picnics, prizes, gifts, and holiday dinners. Established child care benefits are to be included when they are accounted for separately and do not relate directly to a compensation account for direct care employees.

(d) 643 -- Employee Paid Time Off -- Direct Care -- This account is for reporting established vacation, holiday and sick pay programs for direct care employees.

(e) 644 -- COVID Employee Paid Time Off - Direct Care -- This account is for specific COVID 2.5% incentive payment related expense for increased paid time off for worker who become sick.

(f) 645 -- COVID Enhanced Compensation Frontline -- This account is for specific COVID 2.5% incentive payment related expense for enhanced compensation for frontline caregivers who are at risk of exposure to COVID-19.

(g) 651 Compensation -- Director of Nursing Services -- This account is for reporting all compensation received by employee(s) responsible for directing the nursing services of the facility.

(h) 652 Compensation -- Registered Nurses -- This account is for reporting all compensation received by Registered Nurse employees of the facility who provide nursing services, other than the Director of Nursing Services, but including Resident Care Managers. If a Registered Nurse provides nursing services part of the time and carries out other duties the rest of the time, this employee's compensation will be allocated to the appropriate account based on time spent on each activity.

(i) 653 Compensation -- Licensed Practical Nurses -- This account is for reporting all compensation received by Licensed Practical or Licensed Vocational Nurse employees of the facility who provide nursing services. If a Licensed Practical Nurse provides nursing services part of the time and carries out other duties the rest of the time, this employee's compensation will be allocated to the appropriate account based on time spent on each activity.

(j) 654 -- Compensation -- Certified Medical Aides -- This account is for reporting all compensation received by certified medical aides.

(k) 655 -- Compensation -- Certified Nursing Aides and Restorative Aides -- This account is for reporting all compensation received by certified nursing aides and restorative aides not part of the physical therapy department.

(l) 656 Compensation -- Other Nursing Employees -- This account is for reporting all compensation received by non-licensed, non-professional employees who provide nursing services. If such employees provide nursing services part of the time and carry out other duties the rest of the time, these employees' compensation will be allocated to the appropriate account based on time spent on each activity.

(m) 661 -- Compensation -- Activities Employees -- This account is for reporting all compensation of employees engaged in the planning and carrying out of resident recreational activities.

(n) 662 -- Compensation -- Social Workers -- This account is for reporting all compensation of social workers and assistants employed to provide social service activities.

(o) 663 -- Compensation -- Medical Records -- This account is for reporting all compensation of medical records employees.

(p) 664 -- Compensation -- Rehabilitation Employees -- This account is for reporting all compensation of occupational and physical therapists, and technicians, and therapy aides employed to provide resident rehabilitation activities or services. This account will be subdivided in accordance with OAR 411-070-0359(3)(g) on Schedule A to Form SPD 35 or SPD 35A.

(q) 671 -- Compensation -- Religious Employees -- This account is for reporting all compensation for individuals employed who provide religious services.

(r) 672 -- Compensation -- Hospital Employees -- This account is for reporting the expense attributable to hospital employees not related to nursing facility long-term care.

(s) 673 -- Compensation -- COVID Other -- This account is for all other Direct Care compensation related to COVID care.

(t) 681 -- Compensation -- Other Employees -- This account is for reporting all compensation for dentists, barbers, beauticians, research, and other non-identified personnel employed by the facility and must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(u) 752 -- Purchased Services -- Registered Nurses -- This account is for reporting the expense attributable to employment agencies that provide part-time registered nurse employees on a fee and salary basis.

(v) 753 -- Purchased Services - Licensed Practical Nurses -- This account is for reporting the expense attributable to employment agencies that provide part-time licensed practical nurse employees on a fee and salary basis.

(w) 754 -- Purchased Services -- Certified Medical Assistants -- This account is for reporting the expense attributable to employment agencies that provide part time certified medical assistant employees on a fee and salary basis.

(x) 755 -- Purchased Services -- Certified Nursing Assistants & Restorative Aides -- This account is for reporting the expense attributable to

employment agencies that provide part-time certified nursing assistant and restorative aide employees on a fee and salary basis.

(y) 756 -- Purchased Services -- Other Nursing -- This account is for reporting the expense attributable to employment agencies that provide part-time other nursing employees on a fee and salary basis, and must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(14) DIRECT CARE SUPPLIES -- These accounts include supplies and services used in providing direct resident services.

(a) 811 -- Education & Training -- This account is for reporting registration, tuition, and book expense associated with education and training of direct care personnel.

(b) 812 -- Nursing Assistant (Aide) Training and Competency Evaluation -- This account is for reporting all expenses associated with OAR 411-070-0470 (which excludes salaries of nurse aide trainees).

(c) 816 -- Nursing Supplies -- This account is for reporting all medical supplies consumed by this department, exclusive of oxygen, used in providing direct care services.

(d) 819 -- Physician Fees -- This account is for reporting all expenditures for physician treatment, services and evaluation of the resident.

(e) 820 -- COVID Supplies -- This account is for the reporting of all related supplies incurred for COVID expenses. This account must be explained in detail on Schedule A.

(f) 826 -- Oxygen Supplies -- This account is for reporting the expense of all oxygen (gas) and concentrator rentals.

(g) 836 -- Pharmacy Supplies -- This account is for reporting the expense of all materials utilized in the facility pharmacy operation.

(h) 837 -- Drugs and Pharmaceuticals -- Nursing Home -- This account is for reporting all expenditures meeting the criteria of 411-070-0085(2)(j).

(i) 838 -- Drugs & Pharmaceuticals -- Prescriptions -- This account is for reporting all expenditures for legend drugs and biologicals prescribed by a licensed physician and not meeting the criteria of 411-070-0090.

(j) 846 -- Laboratory Supplies & Fees -- This account is for reporting the expense of all materials utilized in the facility laboratory operation and fees paid for non-employee pathologist and laboratory technician services.

(k) 856 -- X-Ray Supplies & Fees -- This account is for reporting the expense of all materials utilized in the facility X-Ray department and fees for non-employee radiologists and X-Ray technician services.

(l) 859 -- Equipment Rental -- Chargeable -- This account is for reporting chargeable equipment rental costs for equipment used in direct care services cost categories.

(m) 861 -- Barber & Beauty -- The cost of non-employee barber and beautician services will be reported in this account.

(n) 863 -- Medical Records Supplies -- This account is restricted to materials and software used in resident charting, including data processing for medical records.

(o) 866 -- Activities & Recreational Supplies -- This account is for reporting the expense of entertainers, and all materials used in providing resident recreational activities. Related transportation is to be reported in Account 427.

(p) 876 -- Rehabilitation Supplies & Fees -- This account is for reporting the expense of all materials used in providing occupational and physical therapy including fees for non-employee related services. This account must be subdivided in accordance with OAR 411-070-0359(3)(I) on Schedule A to Form SPD 35 or SPD 35A.

(q) 882 -- Utilization Review -- This account is for reporting the expenses of all non-employee fees associated with utilization review.

(r) 889 -- Consultant Fees -- This account is for reporting all expenditures for consultant fees, including travel and lodging, exclusive of dietary and management consultants and must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(s) 899 -- Miscellaneous -- Expenses reported in this account must be explained in detail on Schedule A to Form SPD 35 or SPD 35A.

(15) VENTILATOR ASSISTED PROGRAM EXPENSES -- These accounts include supplies and services used in the ventilator assisted program.

(a) 950 -- Ventilator Unit Medical Director Compensation -- This account is for reporting all compensation received by the Ventilator Unit Director who provides services for the Ventilator Assisted Program residents.

(b) 951 -- Nursing Compensation -- Ventilator Assisted Nurses - This account is for reporting all compensation received by nurse and nursing assistant employees of the facility who provide nursing services for Ventilator Assisted Program residents.

(c) 952 -- Respiratory Therapist Compensation -- Ventilator Assisted - This account is for reporting all compensation received by Respiratory Therapist employees or contractors of the facility who provide therapy services in Ventilator Units.

(d) 953 -- Contracted Nursing -- Ventilator Assisted - This account is for reporting the expense attributable to employment agencies that provide registered nurse employees on a fee and salary basis in a Ventilator Unit.

(e) 954 -- Ventilator Rental -- This account is for reporting expense of a ventilator.

(f) 955 -- Oxygen and Medication -- Ventilator Assisted - This account is for reporting the expense of all oxygen (gas) and concentrator rentals and is for reporting all expenditures meeting the criteria of 411-070-0085(2)(j) in a Ventilator Unit.

(g) 956 -- Other Ventilator related Supplies -- This account is for the reporting of other related supplies incurred in a Ventilator Assisted Program.

(h) 957 -- Other (Identify) -- Ventilator Assisted - This account is for all other expenses incurred in a Ventilator Assisted Program.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

411-070-0470 Nursing Assistant Training and Competency Evaluation Programs Request for Reimbursement

(Amended 04/01/2016)

(1) The Omnibus Budget Reconciliation Act (OBRA) of 1987 and 1990 requires that any nursing assistant employed in a nursing facility completes a competency evaluation program. Medicaid reimburses a Medicaid certified nursing facility for the Medicaid share of the allowable cost directly related to meeting the nursing assistant training and competency evaluation requirement.

(2) A facility must notify, in writing, the nursing assistants upon hire that the nursing assistant may receive reimbursement up to 12 months after completing

a Nursing Assistant Training and Competency Evaluation Program (NATCEP) training program. Failure to notify or failure to reimburse an eligible nursing assistant, shall result in an assessment for imposition of sanctions.

(3) The nursing facility must reimburse newly employed Certified Nursing Assistants who have personally paid for NATCEP costs. The facility is not required to reimburse the nursing assistant in cases where the expenses were paid by an employer or education training program or reimbursed by a previous employer.

(4) REQUEST FOR REIMBURSEMENT. Medicaid certified nursing facilities must file a NATCEP request for reimbursement with the Department that meets the following standards:

(a) As of January 1, 2013, all requests for reimbursement must be submitted electronically. A facility must submit a request for reimbursement within 12 months after completing a NATCEP training program or reimbursing a nursing assistant as described in section (3) of this rule. The request for reimbursement must identify all costs incurred and related revenues (not including NATCEP payments from the Department) received during the reporting period.

(b) A request for reimbursement must:

(A) Be submitted electronically on a system provided by the Department.

(B) Include actual costs incurred and paid by the facility. The Department may not reimburse a facility prospectively.

(C) Include all revenue (not including NATCEP payments from the Department) received by the facility for conducting the approved

nursing assistant training. All revenue must be used to offset the costs incurred and paid in the reporting period.

(D) The facility must maintain and have available for review the appropriate documentation, as described in section (8) of this rule, to support each specific area identified for payment by the Department. Failure to provide required documentation, when requested, shall result in an overpayment to the facility. The facility must repay any overpayment to the Department within 60 days of receipt of notification.

(E) Include all appropriate NATCEP costs and revenues only. NATCEP costs, including costs disallowed, must not be reimbursed as part of the facility's bundled rate. However, NATCEP costs, revenues, and reimbursement must be included on the facility's annual Nursing Facility Financial Statement (NFFS).

(F) Include only true and accurate information. If a facility knowingly, or with reason to know, files a request for reimbursement containing false information, such action must constitute cause for termination of the facility's provider agreement with the Department. Providers filing false requests for reimbursements may be referred for prosecution under applicable statutes.

(5) CHARGING OF FEES PROHIBITED. The nursing facility must not charge a trainee any fee for participation in NATCEP or for any textbooks or other materials required for NATCEP if the trainee is employed by or has an offer of employment from a nursing facility on the date on which the NATCEP begins.

(6) FEES PAID BY EMPLOYER.

(a) All charges and materials required for NATCEP and fees for nursing assistant certification must be paid by the nursing facility if it offered employment at the facility on the date training began.

(b) If a nursing assistant who is not employed by a Medicaid certified facility or does not have an offer of employment by a Medicaid nursing facility on the date on which the NATCEP began becomes employed by, or receives an offer for employment from a nursing facility within 12 months after completing a NATCEP, the employing facility must reimburse the nursing assistant within the first three months of employment. Reimbursement must include any NATCEP fees for tuition, enrollment and textbook costs, testing fees, or other required course materials up to the amount determined by the Department that was paid by the nursing assistant. Evidence the nursing assistant paid for training must include receipt of payment and the graduation certificate from the school.

(c) Such reimbursement must be calculated on a pro rata basis. The reimbursement must be determined by dividing the cost paid by the nursing assistant by 12 and multiplying by the number of months during this 12-month period that the nursing assistant worked for the facility. The facility must claim the appropriate pro rata amount on each request for reimbursement it submits not to exceed the lesser of 12 months or the total number of months the nursing assistant was employed at that facility. The facility must maintain evidence provided by the nursing assistant of the training costs incurred at an approved training facility.

(d) A facility shall reimburse a nursing assistant before submitting a request for reimbursement from the Department.

(7) FACILITY REIMBURSEMENT BY THE DEPARTMENT. The Department shall reimburse the facility for the Medicaid portion of the costs described in this section unless limited by the application of section (4) of this rule. This portion is

calculated by multiplying the eligible costs paid by the facility by the percentage of resident days that are attributable to Medicaid residents during the reporting period. The Department’s payment to the facility for the NATCEP cost is in addition to payments based upon the facility's bundled rate.

(a) EMPLOYEE COMPENSATION. Reimbursement for trainer hours must not exceed one and a one-third times the number of hours required for certification. A facility may claim reimbursement for the portion of an employee's compensation attributable to nursing assistant training if:

(A) The employee meets the qualifications of 42 CFR 483.152 and OAR chapter 851, division 061;

(B) The employee directly conducts training or testing in an approved program;

(C) The employee's compensation, including benefits, is commensurate with other licensed nurse compensation paid by the facility;

(D) The employee's total compensated hours do not exceed 40 in any week during which NATCEP reimbursement is claimed;

(E) No portion of the claimed reimbursement is for providing direct care services while assisting in the training of nursing assistants if providing direct care services is within the normal duties of the employee; and

(F) The facility provides the Department with satisfactory documentation to support the methodology for allocating costs between facility operation and NATCEP.

(b) TRAINING SPACE AND UTILITIES. Costs associated with space and utilities are eligible only if the space and utilities are devoted 100 percent to

the NATCEP. The facility must provide documentation satisfactory to the Department to support the need for, and use of, the space and utilities.

(c) TEXTBOOKS AND COURSE MATERIALS. A portion of the cost of textbooks and materials is eligible if textbooks and materials are used primarily for NATCEP. The portion reimbursable is equal to the percentage of use attributable to NATCEP. "Primarily" means more than 50 percent. The facility must provide satisfactory documentation supporting the NATCEP need for and percentage of use of textbooks and materials.

(d) EQUIPMENT. A portion of the cost of equipment is eligible if used primarily for NATCEP. However, equipment purchased for $500 or more per item, must be prior approved by the Department to qualify for reimbursement. The portion reimbursable is equal to the percentage of use attributable to NATCEP. "Primarily" means more than 50 percent. The facility must maintain satisfactory documentation supporting the NATCEP need for and percentage of use of the equipment. Disposition of equipment and software purchased in whole or in part under the Title XIX Medicaid Program must meet the requirements of the facility's provider agreement.

(e) CERTIFICATION FEES. Nursing assistant certification and recertification fees paid to the Oregon State Board of Nursing for facility employees are eligible.

(f) REIMBURSEMENT FOR NURSING ASSISTANTS. Reimbursement provided to nursing assistants pursuant to section (6) of this rule are eligible. The training must have occurred at an approved training center, including nursing facilities in Oregon or other states. If a facility chooses to reimburse the nursing assistant’s full amount in one request, the facility may not recoup payment from a nursing assistant if the nursing assistant’s employment ends, regardless of cause.

(g) CONTRACT TRAINERS. Payment for nursing assistant training classes provided under contract by persons who meet the qualifications of 42 CFR 483.152 are eligible for reimbursement. For this purpose, either the facility or the contractor must be approved for NATCEP. Allowable contract trainer payments shall be limited to the lesser of actual cost or the salary calculation described in section (7)(a) of this rule.

(h) INELIGIBLE COSTS - TRAINEE WAGES. Wages paid to nursing assistants in training are not eligible for NATCEP reimbursement, but may be claimed as part of the daily reimbursement costs.

(i) REIMBURSEMENT FOR COMBINED CLASSES. If two or more Medicaid certified facilities cooperate to conduct nursing assistant training, the Department shall not reimburse any participating facility for the combined training class until all participating facilities have filed a request for reimbursement. For a combined class, the Department shall apportion reimbursement to participating facilities pro rata based on the number of students enrolled at the completion of the first 30 hours of classroom training or in any other equitable manner agreed to by the participating facilities. However, when cooperating facilities file separate NATCEP requests for reimbursements, nothing in this section authorizes the Department to deny or limit reimbursement to a facility based on a failure to file or a delay in filing by a cooperating facility.

(8) RECORDKEEPING, AUDIT, SANCTIONS, REPORTING, AND APPEAL.

(a) The facility must maintain supportive documentation for a period of not less than three years following the date of submission of the NATCEP request for reimbursement. This documentation must include records in sufficient detail to substantiate the request for reimbursement. If there are unresolved audit questions at the end of the three-year period, the records

must be maintained until the questions are resolved. The records must be maintained in a condition that can be audited.

(b) Each facility must submit a quarterly NATCEP report to the Department using the Department's approved method and format. The report must provide an accurate monthly account of nursing assistant new hires, which includes date of hire, date of completion of an approved Nursing Assistant Level 1 training program, and the date of reimbursement.

(A) The facility must submit the report to the Department no later than the end of the month immediately following the end of each calendar quarter. (Example: For the calendar quarter ending March 31, the report must be received no later than April 30.)

(B) Upon the Department's request, the facility must provide documentation to support the quarterly report including payroll records.

(c) All requests for reimbursements are subject to audit at the discretion of the Department. The facility shall be notified in writing of the amount to be reimbursed and of any adjustments to the request for reimbursement. Payment of any amounts due to the Department must be made within 60 days of the date of notification to the facility.

(d) Sanctions and remedies may be provided pursuant to OAR Chapter 411, Division 89. One or more remedies may be imposed by the Department when a facility fails to comply with state regulations. The remedy(s) issued by the Department may be based upon findings of noncompliance with one or more requirements of participation.

(e) A facility is entitled to an informal conference and contested case hearing pursuant to ORS 183.413 through 183.470, as described in OAR 411-070-0435, to protest the reimbursement amount or the adjustment. If

no written request for an informal conference or contested case hearing is made within 30 days, the decision becomes final.

Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

Appendix A

Bundled Rate
Table OAR 411-070-0085

See OAR chapter 410, division 122 for complete information regarding coverage requirements.

HCPCS Code	Narrative Description
E0302	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type siderails, without mattress (weight or need based)
E0304	Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type siderails, with mattress (weight or need based)
E0635	Patient lift, electric, with seat or sling only when client weighs 450 pounds or more (capped rental only)
E1226	Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each
E1399	Durable medical equipment, misc. Includes pressure reducing support surface, Group 2 bariatric only Includes bariatric trapeze bar Includes bariatric commode
E2609	Custom fabricated wheelchair seat cushion, any size
E2617	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware

K0007	Extra heavy-duty wheelchair only when client weighs more than 350 pounds
K0009	Other manual wheelchair/base
K0108	Wheelchair component or accessory, not otherwise specified

Appendix B

Bundled Rate

Table OAR 411-070-0085

OTC ANALGESICS		
Code	Drug/Class Name	Comments
HSN 001820	Aspirin - 325 mg	80 mg form will be covered by OHP
HICL 001866	Acetaminophen	
HSN 003723	Ibuprofen	Dosages that require a prescription for dispensing will be covered by OHP
HSN 003726	Naproxen Sodium	Dosages that require a prescription for dispensing will be covered by OHP
OTC TOPICALS		
Code	Drug/Class Name	Comments
STC 92	Topical Coal Tar Shampoo	
STC 93	Emollients/Protectants	OHP covers Dextranomer (HSN=002363).
HIC3 Q5P	Topical Steroid Cream	Such as Hydrocortisone
HIC3 Q5W	Topical First Aid Cream	Such as Bacitracin or Neosporin

OTC LAXATIVES, ANTI DIARRHEA, ANTACIDS		
Code	Drug/Class Name	Comments
STC 06	Laxatives	Docusate will be covered by OHP
HIC3 D4B	Antacids	
HSN 001228 etc.	Anti diarrhea OTC medication	Such as Kaopectate
OTC COUGH & COLD PREPS		
Code	Drug/Class Name	Comments
STC 16	Cough Medication	
STC 17	Cold Medication	
OTC VITAMINS		
Code	Drug/Class Name	Comments
STC 80-83	Multivitamin	Calcium and Vitamin D preparations prescribed for treatment and prevention of osteoporosis will be covered by OHP
THICKENERS		
Code	Drug/Class Name	Comments
HIC3 U6C	Oral Thickener	Such as Starch, Corn Starch, Xanthan Gum

HIC3 Q5R	Scabacides/Pediculicides	Any product in this class that does not require a prescription for dispensing