
Residential Rate Standardization Implementation

Planning & Updates for July 1, 2019
implementation

April 17, 2019



HEALTH SYSTEMS DIVISION
Adult Mental Health Services

Session overview

- Provider calls on draft standardized rates & simulated fiscal impact
- Proposed rules & response to provider feedback
- Early Adopter Lessons Learned to date
- RTH/F direct care engagement activities & documentation
- Implementation timeline
- Provider feedback for technical assistance, emerging questions

July 1 Go-Live

- Providers will bill new standardized rates for residential services (T1020, or T1019 for YAT) for Oregon Health Plan (OHP - Medicaid) individuals, and for non-OHP individuals in residential
- Behavioral Health contracts will cover only non-OHP individuals and non-covered services
- OHA Leadership and OHA Budget have reviewed the standardized rates' fiscal impacts.
- OHA continues to update the Legislature through Legislative Fiscal Office on the implementation specified in HB 5026-A (2017) requiring the standardized rates implementation.

July 1 – what changes?

Current state

- Provider-negotiated, cost-based rates
- Billing: Code T1020 (T1019 for YAT)
- Some contract service payments to some providers

Future state: July 1 rates

- Standardized rate varies by client's LSI acuity tier
- Billing: Code T1020 (T1019 for YAT)
- Unified and streamlined Medicaid payment for all OHP-eligible individuals

July 1 implementation phase

- Similar to early adopter providers phase, OHA expects a 4-6 month implementation phase (July 1-Dec 31):
 - For billing new rates including individual acuity
 - For reviewing staffing stability
 - To train and support direct care staff and individuals with active engagement
 - To develop daily documentation strategies
 - To begin identifying progress and measures for success

Thereafter, to collaborate with OHA, community partners and providers for best practices and for additional data on emerging issues.

Standardized rates

- Geographic variation: Three regions aligned with Oregon minimum wage law
- Individual level of care needs grouped in tiers relative to acuity needs requiring additional staff engagement:
 - Low acuity (LSI up to 40)
 - Medium acuity (LSI 41-60)
 - High acuity (LSI 61-plus)
- Bed size bands account for economies of scale:
 - 1-5
 - 6-10
 - 11-16

Provider calls on draft rates and simulated fiscal impact

- OHA simulated provider fiscal impacts by:
 - Using December 2018 client roster and LSI scores
 - Assuming full occupancy (using low-acuity Tier 2 for any vacancies in client rosters)
- The draft standardized rates:
 - Assume a balance of individual needs
 - Encourage serving individuals with higher care needs (higher tiers), where appropriate.
- Calls are an opportunity to hear concerns, data and feedback

Contract changes

- Removed from contracts:
 - General fund service payment
 - Rent subsidy payment
- Billing changes:
 - One billing source for Medicaid-eligible clients (MMIS)
 - Non-Medicaid eligible funds payable by invoice through the invoice tracker
 - Elimination of most CARs (service payment and RSCPs)
 - RSCPs billed through MMIS as Retainer Payment

Rule Advisory 3/15 feedback on proposed rules 410-172-0705

- Active engagement and average hours by acuity tier
- Direct care & engagement documentation daily
- Medicaid allowable program costs
- Retainer payment (tier 1) for temporary medical, behavioral or psychiatric absences 30 days or less – similar to “RSCP” will require prior authorization to bill GF
- IQA: Independent face to face assessment; temporary assessment by community partner until IQA assessment available

Residential Treatment Services

- **Direct care “active engagement”**: the explicit direct care staff work in mental health residential treatment facility or home to support personal care and habilitation for an individual’s ADLs and instrumental activities of daily living. Active engagement may include individual or small group staff providing habilitation services. This active engagement excludes an individual’s rehabilitation treatment and services.
- **Licensed/certified staff performing rehabilitative treatment**: 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 for rehabilitation.

Residential program services costs

- Medicaid allowable costs incurred in providing mental health services in residential treatment setting.
- These may include costs incurred to provide services required to directly meet resident needs for mental health habilitation including activities of daily living (ADL) and independent activities of daily living (IADL).
- Allowable indirect services costs may also include operating support such as insurance, utilities, maintenance, dietary (excluding food), laundry, and housekeeping.
- The allowed residential services costs are subject to the specific provisions and limitations set out in these rules.

Costs not included in calculating standardized rates

- Client paid room and board
- Mental health rehabilitation services
- Medical services
- Costs incurred by related organization that are not directly incurred for congregate program services
- Administrative costs in excess 10% of allowed costs
- Program start-up costs

Engagement vs. Supervision Hours

- **Active Engagement Hours** provided by direct care staff work to support personal care and habilitation including ADLs and IADLs.
 - (i) Active engagement may include individual or small group staff providing habilitation services.
 - (ii) Staff engagement may occur before, during or after an individual's ADL and IADL activities, and may include engagement about offsite activities.
- **Supervision Hours** includes the shared hours overseeing patients' general activities throughout the day.
 - Supervision Hours are shared and relatively passive compared to engagement.

Individual acuity & average hours of engagement

- Individual acuity used to determine allocation of active engagement and supervision hours in a billable day to foster a person-centered system supported by HCBS requirements:
 - (a) Low level of need individuals may receive an average of three hours of active engagement daily.
 - (b) Medium level of need individuals may receive an average of five hours of active engagement daily.
 - (c) High level of need individuals may receive an average of seven hours of active engagement daily.

Individual acuity measure

- Acuity may be measured by a Division-approved instrument.
- The Division may use assessments on a temporary basis until the independent assessment is performed by the community partner.
- Providers of independent assessments may include:
 - OHA staff; or
 - The Division's IQA vendor;
- Pursuant to CMS guidance, independent assessments may not be appealed.

When acuity assessments may occur

- Acuity reviews may be authorized by the Division as follows:
 - (a) In preparation for a placement from the OSH
 - (b) As part of an annual review such as 1915(1) eligibility;
 - (c) In preparation for a placement from other sources ; or
 - (d) On an ad hoc basis for residents with a significant change in acuity that lasts longer than 30 days;
- (A) Providers may request the IQA to perform an ad hoc assessment and reauthorization for an individual with a significant change in acuity exceeding 20 points and which lasts longer than 30 days.
- (B) Upon IQA review, the assessment review may be forwarded to the Division Rate Review Committee for possible tier rate adjustment if indicated.

Retainer payment per HCBS

- Subject to CMS approval, retainer payments will replace current Reserved Service Capacity Payments (RSCP) for Medicaid and non-OHP individuals
 - Transitioning process is in development – Training to follow with Billing Training in May 2019
 - Retainer payment for temporary absence 30 days or less for medical, psychiatric, behavioral hospitalization or related absence
 - Requires required documentation and OHA approval for payment
 - Payment is Tier 1 standardized rate

Provider reporting

- Monthly census reporting to OHA is required.
 - At least weekly updates of changes (new referrals, admissions, transfers and discharges)
 - System for provider reporting is in development – Training to follow.

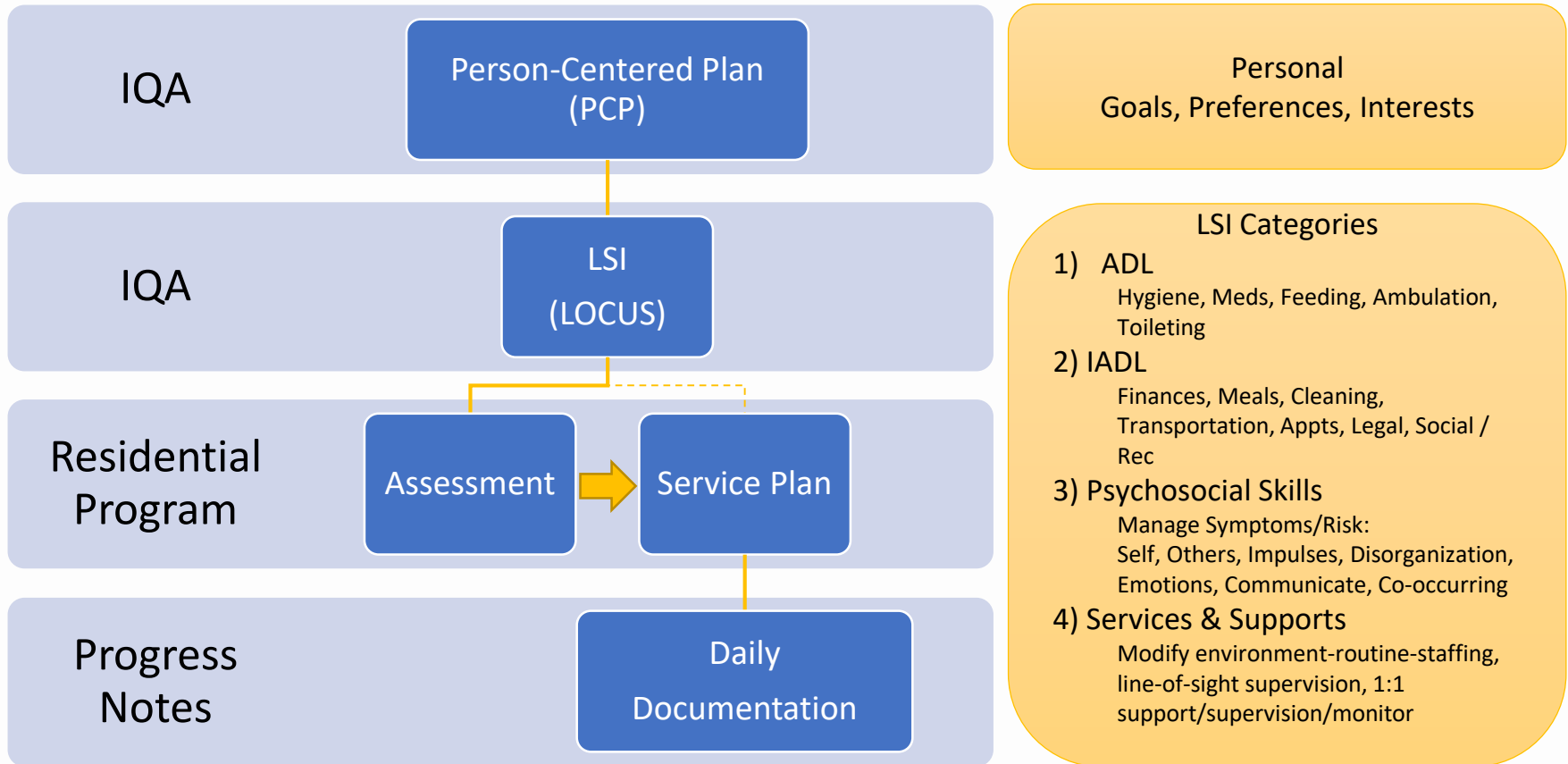
Other proposed rule questions from RAC

- Proposed rules to be formally submitted to Secretary of State
- Public hearing by June 21

Early Adopter Lessons Learned to date

- Client and staff engagement has increased
- Sharing creative ways to engage clients who previously would not engage
- Examples of documentation:
 - Staff using notepads to track activities & response using client coded name, then before shift ends documenting shift notes
- Some providers able to hire needed staff to reach required staffing
- More lessons learned in May 2019 webinar

The Golden Thread



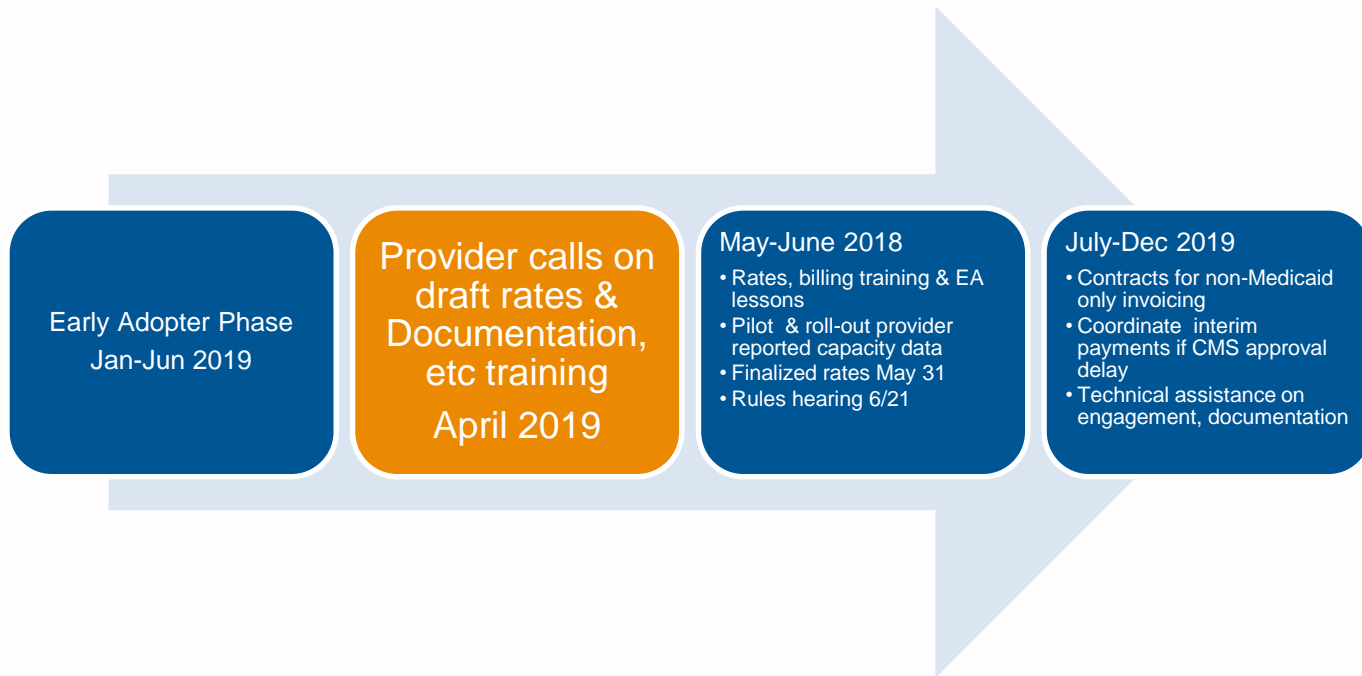
Example One

- Joe's Person-Centered Plan includes a goal for increasing his cooking skills in order to prepare him for greater independence and develop healthy eating habits.
 - LSI and LOCUS identify IADL challenges in preparing meals that support health and medical conditions.
 - Meal preparation is a listed goal for skill development through program assessment and service plan.
- The documentation for the PM shift states, "Joe helped staff make dinner."
 - How might the entry be written to better reflect Joe's progress on his goals?

Example Two

- Sue's Person-Centered Plan includes a goal for her to learn how to perform household cleaning tasks (in addition to keeping her room clean) to help prepare her for a more integrated setting.
 - LSI identifies IADL skills for cleaning and maintaining residence.
 - Cleaning and maintaining residence is a listed goal for skill development through the program assessment and service plan.
- Graveyard staff cleans the facility, so there are few tasks remaining for the next day. Documentation states, "No progress on developing household cleaning skills"
 - What changes could be instituted to address this issue?

Implementation timeline for July 1, 2019



Provider feedback & engagement for Technical Assistance

- Training modules
 - Billing, documentation
 - What else?
- Capacity reporting roll-out
- Monitoring for capacity & financial (claims)
- What are best practices and how to share across system
- Technical Assistance pathways
 - Q&A through email
 - Webinars
 - Site visits
- OHA HSD escalation process

Measures for success

- Residential capacity stability, full occupancy
- Individual engagement & progress
- Facility & home staff engagement & stability

For more information

Questions?

Email

- [MentalHealth.ResidentialTransition@dhsoha.state.or.us\](mailto:MentalHealth.ResidentialTransition@dhsoha.state.or.us)

Website

- <https://www.oregon.gov/oha/HSD/OHP/Pages/MH-Rates.aspx>