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# PERMANENT ADMINISTRATIVE ORDER

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## DMAP 26-2019
CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Standardized Per Diem Habilitation Rates for Mental Health Residential Treatment Programs

EFFECTIVE DATE: 06/28/2019

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RULES:
410-172-0705, 410-172-0730

ADOPT: 410-172-0705

REPEAL: Temporary 410-172-0705 from DMAP 110-2018

RULE TITLE: Residential Rate Standardization

NOTICE FILED DATE: 05/09/2019

RULE SUMMARY: The rules implement rate standardization for residential treatment programs. The resulting tiered rates are based on facility type, facility capacity, region and client needs. Facility types include residential treatment home (RTH), residential treatment facility (RTF), secured residential treatment (SRTF) and young adults in transition (YAT). These rules provide a standardize rate structure for these providers.

RULE TEXT:
(1) The following terms and acronyms have the described meanings when appearing in OAR 410-172-0705:
(a) “Acuity” means the level of residential service and support needs of an individual experiencing functional deficits resulting from the symptoms of a diagnosed mental health condition or complicating medical, behavioral, or cognitive conditions.
(b) “Active Engagement” means service hours provided to individuals in a residential treatment program that support personal care and other habilitative services. Active engagement hours:
(A) May include providing habilitation services to an individual or small groups;
(B) May occur before, during, or after the provision of ADL and IADL services for an individual;
(C) May include offsite activities with program staff;
(D) May not include Psychosocial Rehabilitative Services (PRS).
(c) "Activities of Daily Living (ADL)" means those personal, functional activities required by an individual for continued well-being, health, or safety. Examples of ADL include eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition/behavior;
(d) “Community Mental Health Program (CMHP)” means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific

geographic area of the state under an intergovernmental agreement or direct contract with the Authority. CMHPs are operated pursuant to OAR chapter 309, division 014;
(e) “CMS” means Centers for Medicare and Medicaid Services, the federal agency that administers Medicaid;
(f) “De Minimis Threshold” means the Office of Management and Budget (OMB) threshold of 10 percent for government program-related administrative costs;
(g) “Direct Care” means active engagement and supervision care for individuals in a residential treatment program;
(h) "Division” or “Health Systems Division" means the Oregon Health Authority, Health Systems Division and its employees and authorized agents that is the organizational unit responsible for administration of state and federally-funded medical assistance programs including Title XIX Medicaid and Title XXI State Children’s Health Insurance Program (SCHIP);
(i) “General Ledger” means the main accounting record of a company or organization;
(j) “Habilitation” or “Habilitative Services” means services designed to help an individual attain or maintain their maximal level of independence and includes, but is not limited to, services provided in order to help an individual acquire, retain, or improve skills in ADLs and IADLs, community survival skills, communication, self-help, socialization, and adaptive skills necessary to reside successfully in an individual’s home or a community-based setting;
(k) “Home and Community Based Services (HCBS)” means services and supports that assist eligible individuals to remain in their home and community in accordance with the Code of Federal Regulations and Oregon Administrative Rules;
(L) “Independent and Qualified Agent (IQA)” means Oregon’s contracted vendor to perform functional needs assessments, person-centered service planning service coordination, transition coordination, service authorizations, and utilization review and management for individuals requesting or receiving 1915(i) Home and Community-Based Services, other Medicaid-funded behavioral health services, or state General Fund behavioral health services in an individual’s home or a community-based setting. The IQA conducts initial and annual 1915(i) HCBS State Plan Amendment eligibility determinations and redeterminations;
(m) “Instrumental Activities of Daily Living (IADL)” means those self-management activities performed by an individual on a day-to-day basis but are not essential to basic self-care and independent living. Examples of IADLs include but are not limited to housekeeping, laundry, shopping, transportation, medication management and meal preparation;
(n) “Level of Service Inventory (LSI)” means a person-centered assessment of the residential service and support needs of an individual experiencing functional deficits resulting from the symptoms of a diagnosed mental health condition;
(o) “Minimum Wage Regions” means geographic areas within Oregon in which fixed minimum hourly wage rates are set lower than the minimum wage rate as authorized by ORS 653.025;
(p) “Per Diem” means a payment made for each day an approved service is provided;
(q) “Performing Provider” means the direct care staff member actually providing a service to an individual in a residential treatment program or separately billing a rehabilitative service to an individual residing in a residential treatment program;
(r) "Person-Centered Service Plan (PCSP)” means the written description of the supports, desired outcomes, activities, and resources required for an individual to achieve and maintain personal goals, health, and safety as described in OAR 411-004-0030 and developed in compliance with OAR 309-035-0185 through 0190. The PCSP must be completed and signed prior to the individual receiving HCBS;
(s) “Personal Care” means assistance with the performance of ADLs and IADLs;
(t) “Program Capacity” means the number of beds licensed for residential treatment in a location;
(u) “Provider” means an individual, organizational provider, or CMHP that is enrolled by the Division to provide personal care, other habilitative services, or PSR;
(v) “Psychosocial Rehabilitation Services (PSR)” means medical or remedial services recommended by a licensed physician or other licensed practitioner to reduce impairment to an individual’s functioning associated with the symptoms of a mental disorder or to restore functioning to the highest degree possible;
(w) "Related Organization" means an entity that is under common ownership or control with, has control of, or is controlled by another organization. An entity is related if it has:

(A) Five percent or more ownership interest in the other organization; or
(B) Capacity derived from any financial or other relationship, whether exercised, to directly or indirectly influence or direct the activities of the other organization.
(x) "Residential Treatment Facility (RTF)" has the meaning provided in ORS 443.400(11) subject to exclusions as provided in ORS 443.405;
(y) “Residential Treatment Home (RTH)” has the meaning provided in ORS 443.400(12) subject to exclusions as provided in ORS 443.405;
(z) “Resident” means an individual receiving treatment in a residential treatment program;
(aa) "Residential Services Costs” means costs associated with the provision of mental health services to individuals in residential treatment programs. Costs include direct and indirect services required to meet an individual’s assessed needs for personal care and other habilitative services. Residential services costs do not include costs related to providing psychosocial rehabilitation services (PSR);
(bb) “Residential Treatment Program” means a RTF, RTH, SRTF, and YAT facility that is licensed to provide mental health services but does not include adult foster homes as defined in OAR 309-040-0305;
(cc) “Retainer Payment” means a payment made for medical, behavioral, or psychiatric related temporary absences of 30 days or less from residential treatment programs for which the Division has provided prior authorization;
(dd) "Secure Residential Treatment Facility (SRTF)" has the meaning provided by OAR 309-035-0105(60);
(ee) "Standardized Rate" means a tiered payment rate for personal care and other habilitative services in a residential treatment program based on individual acuity, program capacity, and minimum wage regions;
(ff) "Start-Up Costs" means one-time costs incurred prior to the first resident being admitted;
(gg) “Supervision Hours” means the staff hours in a mental health residential treatment program for overseeing patients’ general activities throughout the day;
(hh) “Young Adult in Transition Facility (YAT)” means a facility when that facility is providing services to an individual who is developmentally transitioning into independence as defined in OAR 309-019-0105 and is of an age not less than 17 years and six months, and not more than 25 years.
(2) The Division applies a standardized rate for payment of personal care and other habilitative services provided in a residential treatment program.
(3) The Division develops standardized rates with a standardized rate methodology based on data from residential treatment programs that is collected and analyzed by an independent third party. The independent third party must collect and analyze provider general ledger cost data for the most recent full year of operation and must examine job classification and wage data.
(4) The analysis of the independent third party referred to in section (3) must:
(a) Align general ledger data;
(b) Evaluate the intensity of the staffing needs in terms of client acuity and level of need;
(c) Determine the cost of active engagement hours and supervision hours;
(d) Analyze program capacity to account for direct care and support costs related to the number of individuals in the home;
(e) Analyze geographic cost variations.
(5) The Division shall re-evaluate provider general ledger data at five-year increments.
(6) Subject to legislative funding and approval, the Division may trend the standardized rate to the annual Consumer Price Index (CPI) the state applies for the state’s minimum wage.
(7) Standardized rates for residential treatment programs are intended to pay for the following:
(a) Residential services costs for individual services and supports for residents of residential treatment programs including ADLs, IADLs, other habilitation services, and related indirect costs;
(b) Five percent vacancy rate for providers to use as a reserve.
(8) The following cost items may not be included in the calculation of standardized rates:
(a) Resident paid room and board;

(b) Psychosocial rehabilitation services;
(c) Medical services;
(d) Costs incurred by a related organization that are not directly incurred for residential treatment program services;
(e) Administrative costs in excess of the de minimis threshold of ten percent of allowed costs; and
(f) Program start-up costs.
(9) The Division may use residential services costs in developing standardized rates as follows:
(a) On request of the Division, residential treatment programs must provide general ledger cost data that capture the most recent full year of operation;
(b) The Division may analyze provider costs by aggregating general ledger information from multiple residential treatment programs to identify relationships between direct care costs and other cost components such as employee benefits, training, transportation, and program-related facility costs;
(c) The Division may calculate the rates for each rate tier based on the amount and type of direct care hours, including active engagement hours and supervision hours.
(10) The maximum allowable rate the Division pays per client under the standardized rate methodology shall be according to rate tiers. The Division shall publish a table with specific rate amounts in the Behavioral Health Fee Schedule. Tiers shall be defined by but not limited to the following variables:
(a) Levels of need based on individual acuity;
(b) Program type and capacity; and
(c) Minimum wage regions.
(11) The standardized rate tier is assigned to an individual based upon an independent face-to-face assessment of an individual's need and acuity that is documented in a PCSP. The assessment classifies residents and prospective residents of residential treatment programs into acuity-based tiers of:
(a) Tier 1 for either an empty bed or an individual whose acuity assessment significantly improves to no longer require the level of support provided in a residential setting, but the individual has chosen to remain in the residential setting;
(b) Tier 2 for an individual with an LSI of 40 or less;
(c) Tier 3 for an individual with an LSI of 41-60;
(d) Tier 4 for an individual with an LSI of 61-79; and
(e) Tier 5 for an individual who is in a residential treatment home or facility that is not part of a secure or young adults in transition program and who is either of the following:
(A) An individual with an LSI of 80 or more; or
(B) An individual with an LSI of less than 80 who the IQA and the Authority agree meets one of the following severity of need criteria, either temporarily during rehabilitation or ongoing, and who is approved for Tier 5 level of care under subsection (11) (f) of this rule:
(i) The individual's medical, behavioral, or cognitive diagnosis severely interferes with treatment and self-care with PCSP and requires frequent monitoring and redirection throughout the day; or
(ii) The individual's intensity and frequency of care varies, and the individual requires frequent monitoring and redirection to prevent decompensating episodes and potential harm to self or others.
(f) Approval of Tier 5 level of care under the provisions of subsection (11)(e)(B) for each initial or additional time period must be based on an evaluation of the individual's PCSP, progress, and continued severity of need and may include:
(A) Approval for an initial period not to exceed three months;
(B) Approval for an additional six-month period; and
(C) Approval for additional periods of 6-12 months.
(12) Client individual acuity used to determine the standardized rate in the Division's table shall be measured by an LSI instrument approved by the Division.
(13) The Division may designate providers of assessments of client individual acuity, which may include:
(a) The Authority staff qualified to perform an assessment;
(b) The Division's contracted IQA; or

(c) Other entities specified by the Authority.
(14) The Division may authorize acuity reviews for the assignment of individuals to residential treatment rate tiers as follows:
(a) In preparation for a placement from the Oregon State Hospital (OSH) to a residential treatment program;
(b) In preparation for a residential treatment program placement from sources other than OSH;
(c) As part of an annual review by IQA for HCBS eligibility redetermination; or
(d) For residents with a significant change in acuity that lasts longer than 30 days.
(15) Providers may request the IQA to perform an assessment and reauthorization of services for an individual with a significant change in acuity exceeding 20 points on the LSI instrument and lasting longer than 30 days.
(16) The Division may pay for services under the standardized rate methodology only when all the following requirements have been met with respect to the service:
(a) All individuals must receive daily supervision;
(b) Tier 2 must receive an average of three or more hours of active engagement daily;
(c) Tier 3 must receive an average of five or more hours of active engagement daily;
(d) Tier 4 must receive an average of six or more hours of active engagement daily;
(e) Tier 5 must receive an average of seven or more hours of active engagement daily;
(f) A performing provider in residential treatment programs, including a provider of habilitation and PRS, must be enrolled with the Division and identified in claiming services as the performing provider;
(g) A residential treatment program must have sufficient staff to meet active engagement and supervision hours as required by subsections (a), (b), (c), (d), and (e) of this section during engagement hours. Refer to OAR 309-035-0135 for licensed residential treatment program staff requirements;
(h) A residential treatment program shall maintain adequate records to accurately substantiate all amounts reported in a general ledger and other cost statements;
(i) A residential treatment program must document at least daily the specific individual personal care and other habilitative services including skills building and other activities provided to enhance community integration, the individual's response to services provided, and planned activities related to the individual's assessment and PCSP;
(j) Upon request of the Division, a residential treatment program must provide monthly site-specific census data that includes individuals' acuity assessment scores and any discharges or referrals and must report changes to submitted census data at least weekly.
(17) The Division's payment of Medicaid allowable standardized rates for residential treatment program services including personal care and other habilitation services is considered payment in full and precludes any General Fund contract or other supplemental funding for Medicaid-allowable costs and services.
(18) Residential treatment program providers may not:
(a) Collect funds from any resident in excess of the room and board costs;
(b) Accept funds from any other source for services paid by Medicaid; or
(c) Submit claims for individual habilitation or PSR services that duplicate the per diem payment for residential personal care and other habilitation services.
(19) Standardized rates developed using Medicaid-allowable costs, policies and processes apply when the Division makes payment for services to non-OHP residents of residential treatment programs.
(20) Beginning July 1, 2019, PRS provided to residents of a residential treatment programs must be billed using individual services or unit billing, and the Division may not pay PSR using bundled per diem rates.
(21) The Division may pay a retainer payment to residential treatment programs:
(a) The Authority may pay a retainer payment for residents in residential treatment programs for medical or psychiatric related temporary absences lasting 30 days or less;
(b) The Division may authorize and make a payment when an individual is absent in order to be:
(A) Admitted to an acute care hospital;
(B) Admitted to a respite facility to avoid re-hospitalization or revocation of a conditional release order; or

(C) Transferred from a hospital, or another residential setting.

(c) A retainer payment for temporary absences of 30 days or less from residential treatment programs requires the Division prior authorization. A prior authorization request must include:

(A) Requested dates of service;

(B) HCPCS or CPT procedure code requested;

(C) The amount of service or units requested; and

(D) Additional clinical information supporting medical or psychiatric justification for the services requested, particularly the medical or psychiatric rationale for temporary absence.

(d) The retainer payment is payable at the Tier 1 rate.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 430.640

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715

AMEND: 410-172-0730

RULE TITLE: Payment Limitations for Behavioral Health Services

NOTICE FILED DATE: 05/09/2019

RULE SUMMARY: The rules implement rate standardization for residential treatment programs. The resulting tiered rates are based on facility type, facility capacity, region and client needs. Facility types include residential treatment home (RTH), residential treatment facility (RTF), secured residential treatment (SRTF) and young adults in transition (YAT). These rules provide a standardize rate structure for these providers.

RULE TEXT:

(1) Services shall be subject to periodic utilization review to determine medical appropriateness.

(2) If a review reveals that a recipient received less than active treatment, payment may not be allowed under these rules and prior authorization may be cancelled.

(3) The Division may make no payment for services if the Division or designee has determined the service is not medically appropriate.

(4) Residential treatment services are provided to Medicaid Title XIX eligible individuals in facilities with 16 or fewer beds. Payment is excluded for individuals in “institutions of mental diseases” (IMD) who are over age 18 and under age 65. IMDs are defined in 42 CFR 435.1010.

(5) For residential facilities, the Division shall pay for the day of admission but may not pay for the day of transfer or discharge.

(6) Medicaid may not reimburse costs associated with room and board for recipients residing in Authority licensed residential treatment programs.

STATUTORY/OTHER AUTHORITY: ORS 413.042, 430.640

STATUTES/OTHER IMPLEMENTED: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715