

Adult Mental Health Residential Services

Questions and answers for Oregon residential facilities and programs

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Capacity reporting

What does capacity reporting replace?

Capacity reporting replaces weekly referral and discharge reporting.

Monthly CHOICE reporting and weekly census reports continue unchanged. CHOICE report is monthly and details other data elements.

Currently the weekly census report includes all referrals, not just referrals accepted to waitlist.

Will this change to only referrals accepted to the waitlist?

At this present time, this requirement will not change while we establish a database.

Will this form replace the weekly report/census that is sent to KEPRO currently?

No, continue to report to KEPRO. With new IQA, OHA will review reporting to IQA and consolidate requests where possible while maintaining weekly visibility of occupancy and empty beds across the residential system.

Will we need to continue to enter MOTS data that is the same as the capacity report?

Yes, continue MOTS data submission.

Will this data help providers know when a waitlisted person is placed at another facility?

Yes, that is one expectation of the capacity reporting.

Referrals are sent to all programs, so would all programs report the same individuals on waitlists? There is a separation between those referred, and those waitlisted/approved. Does this mean that only the program approving the referral would list the individual, or would we still list all referred?

For capacity, providers report all referrals they receive. We understand that this may seem redundant. We hope that once a database is established, some reporting protocols can be merged to reduce redundancy.

Do you only want referred individuals who have been accepted/waitlisted on the spreadsheet, or all currently referred individuals, regardless of referral disposition?

Currently referred individuals as well as those who have been waitlisted.

What if they were admitted on civil commitment but are no longer? Would you keep the admission type as civil and legal status as voluntary?

That is correct. The resident would be considered voluntary unless the resident has a guardian. In that case the provider would select "guardian."

I assume an individual might admit under a civil commitment, say under trial visit in a non-secure program, and then become voluntary when their trial visit expires. Would this be an example of these two items having different entries?

The resident would come into the program as civil. The provider would at the time of capacity reporting enter that resident as civil. When the trial visit expires, the provider would then change the legal status to "voluntary." This would remain 1 entry.

Would we need to report referrals that are under review/not appropriate? If they have been referred but not screened yet should we enter them in the spreadsheet?

Yes. The provider would select "under review."

In the dropdown under the Referral Disposition section of the capacity report, there is no choice for Refused Placement. Can that be added?

No. OHA is capturing denials in any form using the "Denial" dropdown. Refused placement should be marked as denial.

Who reports a referral?

If Program A sends an individual referral to Program B, then Program B would report the referral.

For waitlisted individuals, is that the entirety of the county waitlist, or those who are potentially moving forward to admit within a specific timeframe?

Capacity reporting is to provide OHA weekly and monthly snapshots of residential. So that means individual referrals that the provider has received. Who is on the wait list? What referrals have been received? And the status of the reported referrals.

Does the discharge column have a dropdown option to reflect when a resident elopes from a program/setting? Often providers do not know where the resident necessarily discharged to. OHA asks that providers wait 72 hours before reporting an elopement on the capacity form. This allows time for the provider to find out the resident's current status/location. If after 72 hours, the resident's status is still unknown, then the provider would report "homeless." This process is for capacity reporting only. Please follow the OARs concerning elopement/eviction and so forth.

The resident tab has a column for "discharge date." How long would you like discharged residents to stay on the report?

Once the discharge date has passed and the bed is open, the provider can take that former resident off their reporting form.

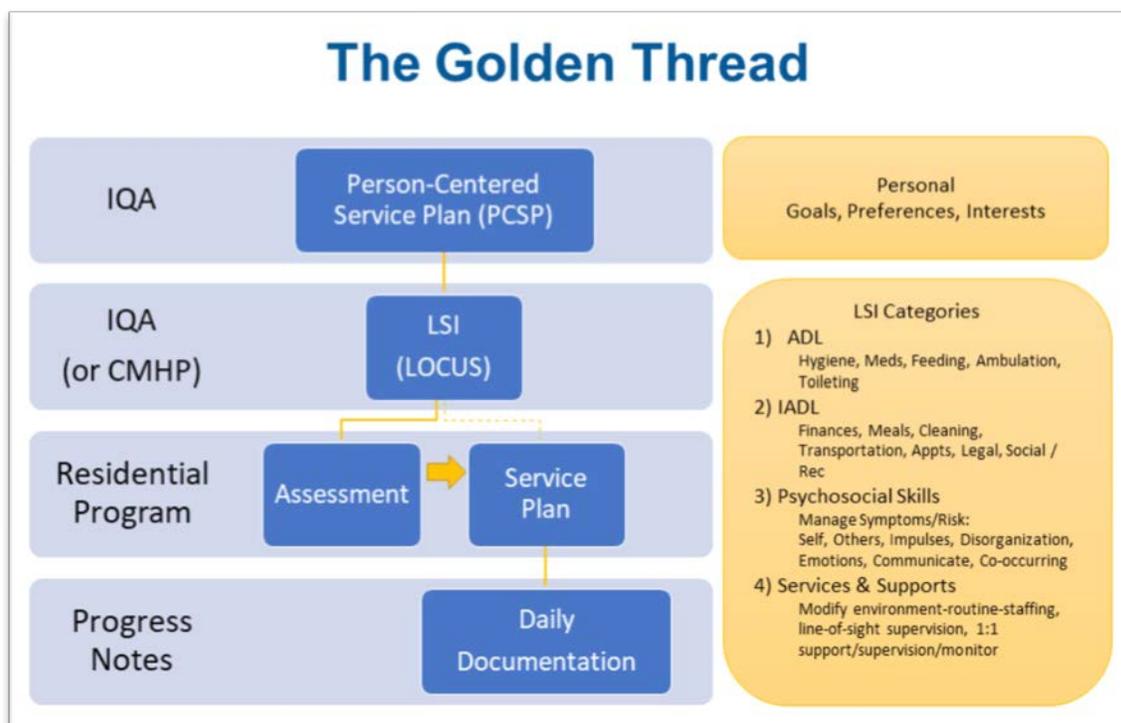
Documentation: Residential Services

Are providers expected to document the full supervision and active engagement hours per day as identified by the tier matrix?

Yes. OHA expects providers to record the individual's progress daily, to include:

- Individual engagement activities,
- The individual's response,
- Any intervention required (e.g., reminders or cueing),
- Progress and plan for next day, and
- What remains to accomplish care plan goals.

For the billed T1020 direct care services, OHA expects more progress notes, rather than a cut and paste list of daily activities.



Additionally, documentation standards for 1915(i) HCBS state plan options services are described in 410-173-0045, including the following:

(3) Providers shall document services and supports provided to the individual and how the services and supports relate to identified goals and objectives outlined in the PCSP.

(4) Providers shall document the services and supports addressing the following HCBS qualities:

- (a) Employment and volunteer opportunities;
- (b) Individual choice of community activities and community access;
- (c) Access to and control of personal resources; and
- (d) Strategies identified in the PCSP to ensure the health and safety of the individual or others.

Outpatient rehabilitation services billed separately from T1020 direct care require clinically appropriate documentation for each occurrence.

We need time to reprogram our EMR for these changes and train staff if we need to change our documentation to match these activities.

Electronic Health Record (EHR) systems are not required for documentation.

For example, Early Adopter providers included a range of documentation methods:

- Some providers' direct care staff used a notepad for engagement activities throughout the day to assist with end-of-shift daily documentation.
- Other early adopter providers had EHR capability.
- Others developed a daily documentation tool which worked for their operation.

Can we use a daily shift note to prove engagement hours? or do we need a bunch of individual notes?

That's fine. Daily shift notes should include the extent of daily engagement and follow the golden thread.

Will the documentation requirements be the same when submitting POC? (Treatment plan, assessment, progress notes, service plan)

For the POC service authorization, the IQA will review all pertinent documentation to make a determination regarding services. It's in the provider's best interest to offer whatever documentation supports the request.

Daily documentation of staff engagement and individual response following the golden thread may represent personal care and habilitation progress notes for residential services distinct from rehabilitative services documentation.

When the assessment is written, we don't have access to the person-centered service plan (PCSP), so how can we have the PCSP guide the golden thread when it isn't available? Do we need to circle back around once a PCSP is available to complete an assessment update?

Yes, that's certainly a viable option if you can't get the PCSP at the time of admission.

Independent and Qualified Agent (IQA)

Does OHA know yet who will be the new IQA?

Yes, the letter of intent was sent out Friday, August 16, 2019. Contract negotiations are in process.

If KEPRO's role is to assess the individual's acuity, are they planning to be onsite to evaluate each resident?

Yes, the IQA's annual 1915(i) eligibility redetermination requires face-to-face individual assessment with LSI, LOCUS, and the person-centered service plan. The assessment should include interview with guardian if applicable, staff and pertinent others subject to the individual's choice, as well as review of relevant documentation.

How often are person centered service plans supposed to be completed by the IQA?

Annually as a part of the 1915(i) eligibility determination assessment.

Will the IQA provide LSIs while the individual is at OSH? Providers are asking for the referral to include the LSI. Will providers receive acuity measures before they accept an individual stepping down from OSH?

The IQA is contracted to assess individuals on the State Hospital Ready to Transition (RTT) list within 30 days of the anticipated discharge.

OHA is working to facilitate inclusion of the LSI, LOCUS and PCSP in the discharge packet.

OHA expects providers to take referrals even if LSI is not provided. Prior assessments and documentation provide enough information about an individual's level of care needs for referral consideration.

Who determines the IQA designee?

Per OAR 410-172-0705:

(13) The Division may designate providers of assessments of 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.

According to Oregon's CMS-approved 1915(i) State Plan, an IQA is the required independent assessor.

During the transition to a new IQA, and in instances where the IQA-conducted assessment (LSI, LOCUS, PCSP) is not yet conducted, OHA may designate the CMHP to perform the interim assessment.

For those counties where the CMHP operates the residential treatment home/facility, OHA will request expedited IQA assessment to address the Medicaid prohibition from self-referral.

Who does the Person-Centered Service Plan? The IQA?

Yes, the IQA. The person-centered planning team (i.e., the IQA, the provider and CMHP treatment team) convene to discuss the individual's abilities, gather documentation regarding the individual's abilities and document the team meeting to resolve the conflict.

OAR 410-173-0025 (1)(g) states the PCSP shall:

Include strategies for resolving disagreement within the process, including clear conflict of interest guidelines for all planning participants that include:

- (A) Discussing concerns of each person-centered service planning team member and determining acceptable solutions;
- (B) Supporting the individual in arranging and conducting a person-centered service planning meeting;
- (C) Utilizing any available greater community conflict resolution resources;
- (D) Referring concerns to the Oregon Residential Facilities Ombudsman; or
- (E) Following existing, program-specific grievance or complaint processes.

Is there a template for the PCSP?

OHA will be reviewing with new IQA, so not yet.

The CMHP and providers have not been completing the PCSP. My understanding is that the IQA completes those for residential programs. Is KEPRO completing all PCSPs now, or are providers still expected to be completing these?

OHA does not expect providers to complete PCSPs. Providers must request an exception from OHA to do so.

- According to 1915(i) HCBS State Plan and OAR 410-173-0025, the IQA documents the PCSP for the individual.
- Section (2)(c) of the OAR states, "To avoid conflict of interest, the PCSP may not be developed by the provider of HCBS. Exceptions may be granted when the Authority has determined that the only willing and qualified entity to provide case management and develop the PCSP in a specific geographic area also provides HCBS."

In addition to the IQA documenting the PCSP, OHA expects CMHP oversight to continue under Service Element 01.

Are providers still expected to complete a LOCUS with authorizations? At this point AFC providers submit the LOCUS, but RTH/F and SRTF providers do not.

Oregon's State Plan mandates the LOCUS as well as the LSI. The LOCUS was "taken out of circulation" in error. The IQA (not the provider) completes the LOCUS and LSI.

Will KEPRO do service plans for individuals under the PSRB in secure settings?

Yes. The IQA is responsible for conducting the face to face assessment regardless of individual's legal status as PSRB.

Our PSW who is an LCSW does the LSI. Will this change?

Medicaid regulations prohibit self-referral; hence the IQA assessment. The CMHP may conduct an assessment in the interim until the IQA is able to complete one. If a facility is operated by the CMHP, OHA will request the IQA to prioritize the assessment.

Acceptance to the program is based on KEPRO authorization. Will KEPRO authorize without an LSI?

Prior authorization for rehabilitative services does not require an LSI.

The annual Plan of Care service authorization requires assessment including LSI, LOCUS, PCSP, which the IQA must complete.

Intensive Services requests

What documentation should providers submit to request a Tier 5 rate even if a completed PCSP is not available? Will OHA provide a template for the letter from the CMHP affirming need for service? If a template is not provided, will OHA provide CMHPs additional explanation of what is required?

Qualifying criteria:

At least one of the following criteria must be met in order to qualify for intensive services:

Basis of need	Qualifying criteria
Medical need	Full assist of 1:1 for: <ul style="list-style-type: none">■ Use and maintenance of adaptive or medical devices■ Assistance with catheter/ostomy care■ Delegated nursing tasks■ Feeding■ Mobility, transfers, or repositioning■ Toileting, bowel or bladder care
Behavioral/psychiatric/cognitive needs	<ul style="list-style-type: none">■ 1:1 supervision in excess of 8 hours per day■ More than 1:1 supervision to maintain community safety (assaultive destructive, sexual behavior)■ Communication deficits requiring substantial intervention to assist the individual in expressing themselves or understanding communication■ Clinically documented pattern of psychiatric and/or behavioral deterioration without the intensive supports proposed

Process

The provider will send an email to ABH Residential Capacity email:

ABH.residentialcapacityreporting@dhsosha.state.or.us via secure email. This email must include:

- Most recent LSI and LOCUS
- Most recent Person-Centered Service Plan (PCSP)
- Current treatment plan
- Current mental health assessment
- Current history and physical (for exceptional service rate requests based on medical needs)
- Current risk assessment (if applicable)
- Relevant incident reports
- Last 60 days' worth of progress notes
- A one-page synopsis from the provider's perspective as to why intensive services are needed
- A one-page synopsis from the CMHP affirming the need for intensive services
- Completed Intensive Services Rate Determination Request Form

Once the material is received:

A rate review committee member will contact the provider within 5 business days to discuss the issue and/or request additional documentation.

A date will be set for a telephone meeting between the provider and the committee, no later than 10 business days after the initial contact during which the provider can make an argument in support of their request

The committee will give their response within five business days after any additional information is provided as identified during the telephone meeting with the provider

If the provider disagrees with the determination:

The AFC grievance procedure described in the Collective Bargaining Agreement will be followed.

For RTF/RTH, the provider will follow Oregon's Medicaid General Rules for Provider Appeals (OAR 410-120-1560-1865).

Have you addressed specialty residential (i.e., medical RTH)?

A request would be submitted to the rate review committee as described above for consideration on an individual basis.

Will Tier 5 be available for billing starting July 1 if we have documentation to committee or CMHP signoff?

Subject to corroborating documentation, OHA may backdate intensive services requests for an individual to the documented start of intensive care needs, but no earlier than July 1, 2019.

Will individuals who score 80 or higher on the LSI require the additional review process and documentation requirements to make them Tier 5?

Individuals with IQA or CMHP LSIs 80 or over are Tier 5 and do not require the additional documentation or review described above.

Per OAR 410-172-0705 (11)(e), "Tier 5 for an individual who is in a residential treatment home or facility that is not part of a secure or young adult in transition program and who is either of the following: (A) An individual with an LSI of 80 or more [...]"

When will OHA inform providers of the Tier 5 rates for the various program types and sizes?

In early June, OHA sent providers a final rate letter that included the applicable Tier 5 rate for the RTH/F geographic region and capacity size.

Note per OAR 410-172-0705 (11)(e), Tier 5 for an individual who is in a residential treatment home or facility that is not part of a secure or young adult program. SRTF and YAT programs are separately adjusted for required program staffing, and consequently are not subject to Tier 5 rates.

The final rate schedule is posted on the OHP Fee Schedule page.

<https://www.oregon.gov/oha/HSD/OHP/Pages/Fee-Schedule.aspx>

Level of Service Inventory (LSI)

How often will OHA address LSI score changes that change a tier level (or approve them in the MMIS for billing changes)? How often are individuals re-assessed for the level of need? This can change, people get better and sometimes our aging population gets worse.

Per OAR 410-172-0705:

(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.

What do we do when individual refuses to sign because they believe they can do more than what the clinician has indicated?

Document their refusal and the reason for it.

When you say the LSI needs to be "signed-off" on by the county, what does that look like?

- (A) Where referral or placement has occurred before the IQA assessment has been conducted, the CMHP may provide an interim assessment, except where the CMHP is the operator of the home or facility.
- (B) The CMHP oversight is conducting the assessment with the provider, individual and pertinent staff and documentation, pursuant to BH CMHP and Direct provider contract SE01.

Please clarify, will OHA now require a LOCUS for an RTH level of care?

Yes, the State Plan requires the assessment to include the LSI, LOCUS and PCSP.

Who is the best contact for questions about the completion of the LSI (e.g., specific questions regarding each item and how it is interpreted)?

Examples are in the July 25, 2019 webinar posted to the Rate Standardization web page.

OHA is working to provide examples with the LSI manual to also be posted to the Rate Standardization web page:

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

Medicaid Provider Enrollment (OAR 410-120-1260; 410-172-0610)

Does an individual adult RTH or RTF require unique Medicaid provider enrollment and identification number?

Yes, each provider site or facility location requires Medicaid provider enrollment and a unique Medicaid ID to bill as the performing provider.

OHA will be requesting updated provider enrollment agreements in advance of July 1, 2019 implementation.

Licensing must be current to maintain Medicaid provider enrollment and be able to bill for Medicaid services.

Medicaid billing

OAR 410-120-1280. Also see the OHP billing page.

<https://www.oregon.gov/oha/HSD/OHP/Pages/Billing.aspx>

Can a corporate or parent company bill Medicaid on behalf of a home or facility?

Yes, a corporate, parent or billing provider enrolled as a Medicaid provider may bill on a home or facility's behalf with the required business agreement/documentation. However, the specific provider location performing the personal care/habilitation services must be included as the performing provider.

A local community mental health program (CMHP) or other outpatient provider is performing rehabilitative services for resident individuals. How do we bill for these?

The provider performing the rehabilitative services is responsible for billing those services; however, the outpatient provider is required to specify the place of service (i.e. whether it is onsite at your home/facility, or in an outpatient clinic setting).

For Young Adult programs, are there any changes for those of us who use T1019?

All residential treatment homes and facilities should bill the residential services as a per diem rate using T1020 service code and the appropriate modifiers.

OHA determined that the per-unit T1019 billing did not align with the per diem assumptions for the rate methodology. Further, OHA identified audit risk to using the per unit T1019 code for residential services.

If a resident is at the home from the time they get up in the morning to about 9 p.m., then visits their family for an overnight stay, can we still bill for that day of services? We provided service to this resident for most of the day.

OHA may review on a case-by-case basis to understand the extent of residential services provided for the day and the role of the family overnight in the individual's treatment plan. One consideration is whether the individual expected to return for residential services the next day?

Has OHA already sent a list of the modifiers and their meaning?

Please use the appropriate procedure code modifiers when requesting services and submitting claims.

- **HK:** For all services provided in OHA-licensed residential treatment programs use as modifier 1 on the claim.
- **HE:** For services provided in non-secure settings licensed for 6-16 individuals use as modifier 2 on the claim.
- **TG:** For services provided in any setting licensed as secure, use as modifier 2 on the claim.
- **HW:** For services provided to 1915(i) HCBS individuals use as modifier 3 (when reported with HE) or modifier 2 (when reported with HK only).

Non-Medicaid General Fund county/direct contracts

Will General Fund dollars still be available to secure beds when providers accept and hold the bed for the individual?

When standardized rates are implemented, General Fund (GF) contract payments will not continue for Medicaid-eligible individuals. The standard rate will account for Medicaid-allowable program and direct care costs. The Service Payment and Rent Subsidy GF in rate and slots will be removed from contract.

GF payments will continue for non-Medicaid individuals through the invoice tracker starting July 1, 2019.

CMS approved the Retainer Payment to replace the Reserved Service Capacity Payment (RSCP). The retainer payment, formerly the RSCP rate as defined by OAR 309-011-0115, for absences 30 days or less will be the standardized Tier 1 rate for the facility's bed size and geographic location. (See [Retainer Payment](#) for more)

For vacancies other than the defined retainer payment (formerly RSCP) circumstances of absence for less than 30 days for hospitalization (OAR 309-011-0115), current specific circumstances are unchanged. Contact your local coordinator.

No increase given for GF or rent subsidy in July 2017, so we have remained even for the last 4 years and now it looks like our income will go down based on this model. We are still required to keep our ratios, but will we be able to continue to exist with a decrease in revenue?

OHA's goal is to standardize rates and minimize adverse capacity impact. The rate methodology has been augmented to address the wage and housing costs faced by residential providers servicing individuals with SPMI, including trending forward based upon Oregon's minimum wage Consumer Price Index (CPI).

OHA requested all providers to submit their December 2018 individual rosters with LSI to perform rate simulations and test rate assumptions to ensure individual engagement assumptions and accurate staffing and cost reporting.

Will the General Fund county/direct contract payments continue?

These payments will not continue for Medicaid-eligible individuals. This is because the Medicaid-allowable program and direct care costs are unified into the standard rate.

GF payments will continue for non-Medicaid individuals through the invoice tracker.

Will contractors continue to get the pass-through money or is that going away with the tier rating as it is per individual instead of "bed or slot" payment?

Bed and slot pass through dollars stopped with rate standardization July 1, 2019, except for non-OHP individuals. GF payments will continue for non-Medicaid individuals only through the invoice tracker.

What about rental assistance billing?

Rental Assistance for PSRB can be requested using the Rental Assistance Tab worksheet, entered onto the Supervision Tab of SE 30-part C.

Non-Medicaid Eligible Client or Absence for Legal Reasons		
Step	Responsible Party	Action
1.	Provider	Within two business days following the acute/respite care admission of an individual in a community residential program or absence for legal reasons, or within two business days prior to the expiration of a previous approval: <ul style="list-style-type: none"> • Complete the HSD RP form • Send the form via secure email to ABH.ResidentialCapacityReporting@dhsosha.state.or.us.
2.	Contracts Unit (FA)	Access all RP forms received in the ABH.ResidentialCapacityReporting@dhsosha.state.or.us inbox each business day.
3.	Contracts Unit (FA)	Within one business day review and determine approval/denial of the PA request.
4.	Contracts Unit (FA)	Within one business day email the approval/denial to the Provider.
5.	Provider	Once the individual returns to the residential program, or at the expiration of the approved RP request: <ul style="list-style-type: none"> • Complete the Client Status portion of the RP form along with an Invoice, and • Submit to your CMHP to request payment via the Invoice Tracker. Or if you have a direct contract, then request payment via the invoice tracker.
6.	CMHP	Receive and review RP form and Invoice.
7.	CMHP	Submit RP form and Invoice for payment via the invoice tracker.

Please use the subject line: Retainer Payment – (name of home/facility).

If an out-of-county placement doesn't have income, does the placement county process the invoice for room/board/PIF?

There is no out-of-county or placement-county. If the individual resides in your county it is your county's responsibility to coordinate and manage the care for the individual.

Billing for non-Medicaid Individuals

How can a provider bill for residential services for an individual who is not eligible for Medicaid (Oregon Health Plan)?

For individuals in an adult mental health residential setting who are not Medicaid-eligible, contact your local county mental health program (CMHP) to determine whether services are payable through the invoice tracker.

What is the rate for non-Medicaid individuals in residential settings?

Payment and policies follow Medicaid rates and policies, where possible.

Can you revisit the slide on the non-Medicaid payment and changes to CARs?

The CARs are no longer being used effective 07/01/2019.

For individuals in an adult mental health residential setting who are not OHP eligible, contact your local county mental health program to determine whether services are payable through the invoice tracker.

What is the limit on non-Medicaid funding? How does the tracker work?

Please review your contract. If you still have questions, please submit your questions through the abh.residentialcapacityreporting@dhsosha.state.or.us email with the subject line: Contract Questions.

If our contract is with OHA instead of a county, do we still bill through our local county?

No. If you have a non-county direct contract with OHA for an adult residential program then you should also have access to the invoice tracker based on your contract.

Residential Plan of Care (POC) requests

To learn more about residential POC requests, review the Medicaid Behavioral Health provider guidelines (Division 172).

Will a new Plan of Care be required for all individuals with new rates?

No. Approved POCs will continue through the authorized period, even when the rate change is implemented. Providers do not need to request continued POC authorization until the current authorization's end date approaches.

KEPRO's 1915(i) review with independent LSI is once a year. Can providers submit a new LSI when an individual's level changes?

410-173-0025 (2)(h)(A-C) states:

- (h) The person-centered service plan shall be reviewed and revised:
 - (A) At least annually and upon reassessment of functional needs;
 - (B) At the request of the individual or, as applicable, the legal representative or authorized representative of the individual; or
 - (C) When the circumstances or needs of the individual change significantly.

When there are significant changes, to ensure appropriate care, a new LSI may be necessary to determine current abilities.

Standard rates must be based upon independent assessment.

Will KEPRO visit our individuals to do an LSI?

OHA's Independent and Qualified Agent (IQA), currently KEPRO, is required to assess individuals face-to-face as part of their annual 1915(i) eligibility redetermination.

Will OHA amend existing POCs to include the new daily rates?

OHA will work with KEPRO to modify the current MMIS plans of care to reflect the new rates.

Do these rates only encompass T1020? Do they include HK billing? What about the bed payments and rent subsidies that come through our allotments?

Residential services billed with code T1020 are the services impacted by the rate standardization.

HK rehabilitative services continue in parallel, consistent with the individual's treatment plan.

Bed payments and rent subsidy allotments ended with rate standardization July 1, 2019.

For non-OHP individuals in residential, the standardized rate applies, however, the billing is through the Contract invoicing process, not Medicaid and MMIS.

When does the POC need to be sent to KEPRO? is it when they reauthorize with the dates we have now?

The service authorization period for an individual should not change with rate standardization.

The IQA will trigger the annual redetermination review going forward, and the provider packet for redetermination process will change with the new IQA.

Are the auth periods now 12 months instead of 6?

For non-secure residential, the service authorization period is 12 months.

POC authorizations are sent to KEPRO. Where are we going to be sending them starting July 1?

POC authorizations continue to go to KEPRO. Information on submitting to the new IQA will follow as the transition occurs by 12/31/2019.

Rate Methodology

Can you review the Supervision Hours and Engagement hours? Do we consider the supervision hours what is currently our PCS rate and rent subsidy, and the engagement hours the rehabilitative rate?

The rate methodology was built upon the assumption that two primary types of hours existed in the adult residential setting: active engagement hours and supervisions hours.

- Active Engagement Hours were defined as the explicit residential program staff work to support personal care and the instrumental activities of daily living.

- Supervision Hours were defined as the oversight of activities of the individual's personal care throughout the day.

Both types of hour are specific to the personal care or habilitative care provided by a residential home/facility direct care staff. Rehabilitative services are billed separately and are outside the scope of this rate structure.

How did you determine the hours for active engagement? Is that based on any historical data?

The hours of active engagement assumption were informed by input from the OHA transition team. The active engagement hours have historically had limits of 3, 5, and 7 average hours for low, medium, and high engagement needs. OHA tested the active engagement hour assumption through the early adopter program.

Why are engagement hours capped at 7 per day?

The rate methodology relied upon the assumed average engagement hours for each risk grouping. The engagement hours are separate from rehabilitative services and treatment, which are billed separately.

What if a provider's treatment model and staffing are different than the model due to unique characteristics of population seen, resulting in costs that do not align with the standardized rate?

Based on conversations with OHA program staff, the residential direct care services provided are identical, although the business model may differ across the provider types. The general ledger data supports using a single Brick for this service as cost profiles for the different provider types did not differ, nor were there outliers.

In review of the general ledgers, Optumas/JVGA conclude that the service is the same: "The service is the same and general ledgers are consistent."

Are there other factors that are not captured by the LSI that might result in payment outside of the Brick?

The primary factor outside the Brick which was evaluated is the concept of medical acuity which results in increased treatment needs.

OHA re-examined with Optumas whether any required staffing variations for SRTFs and YAT programs were absent from the general ledger data; OHA worked with provider feedback and data to adjust rate assumption impacts specific to SRTFs and YAT programs.

OHA worked with Optumas and provider feedback for individuals with medically and behaviorally complex needs for a higher tier 5 scenario where applicable. OHA also developed the intensive services request process for individuals with complex conditions possibly requiring additional staff support.

OHA may acquire additional data over the first year of implementation to determine whether the tiered acuity adequately incorporates medical or psychiatric complex conditions impacting treatment and self-care.

The December 5, 2018 rate presentation slides showed two different salaries, one for a home health worker and one for personal care services worker. Which of these are used to determine salaries? Also, you mentioned that the salary rate would be a blend between the two wage codes. How do you determine that blend? We have a split of roughly 70% who are QMHAs (and would fit within the Personal Care and Service Workers definition, presumably) and 30% as non-QMHAs and fit under the Home Health Aides. This number fluctuates, we prefer to hire QMHAs, but it depends on the job market and applicants, and it also depends on the program.

JVGA's Bureau of Labor Statistics (BLS) examination was based on the providers staffing pattern data.

The salary blend between the two wage codes was informed by staffing pattern data submitted by the adult residential providers. The blend used gives 66.7% of the weight to Personal Care Service Workers and 33.3% to the Home Health Aides.

Do you include any kind of reserves for capital improvements for facilities in this rate? Does the Brick method account for reserves (e.g., money set aside for capital improvements)?

This standardized Medicaid rate structure is based upon Medicaid-allowable program costs. OHA has built an administrative load of 10% that includes basic administrative costs and additional percentages for the provider to use for their business model. This may or may not be used for capital reserves.

How often will the tier rate be reviewed and adjusted with cost of living? How often will rates be rebased and how is that determined?

OHA is required to live within its legislative appropriation. It is up to the Oregon Legislature to determine if, and when, to make any cost-of-living adjustments. The current model is predicated upon the minimum wage in place as of July 1, 2019. If the State were to increase the minimum wage in 2020 and beyond because of Senate Bill 1532, the wage amount in the model would require legislative funding to be increased to remain consistent with the minimum wage standard.

The methodology's job classification exceeds the minimum wage; the rate structure was trended to the state's minimum wage CPI.

Is there anything that our provider organization should be doing to support funding for this model, or do you feel that the funding is in place to roll programs into this new model? I did not see anything in the Governor's budget related to mental health residential rates.

The provider community needs to be in a position where it can show using empirical data that it is paying at or above the minimum wage.

How often does OHA anticipate changing the payment rate? Whenever a person leaves? Annually?

OHA and Optumas examined individual churn with the early adopter providers, and the incidence of individuals with significant acuity changes across the system.

- An OHA initial assumption is that individuals will infrequently decompensate significantly to require extended hospitalization or prolonged increase in LSI score.
- Individuals are redetermined for 1915(i) eligibility annually by the independent qualified agent (IQA), currently KEPRO. OHA will re-evaluate individual tier rates annually with the 1915(i) redetermination.

What are the 3 different regions to assist in determining the rate table for each MH provider (Rural, Urban and Standard)?

The geographic variation applied to the rate methodology follows Oregon's minimum wage law. Refer to Oregon BOLI for the regions:

<https://www.oregon.gov/boli/WHD/OMW/Pages/Minimum-Wage-Rate-Summary.aspx>

The non-urban rate applies to employers located within the following counties:

Baker	Klamath
Coos	Lake
Crook	Malheur
Curry	Morrow
Douglas	Sherman
Gilliam	Umatilla
Grant	Union
Harney	Wallowa
Jefferson	Wheeler

Who decides what tier each individual is on?

Rate standardized rate methodology is based upon unbiased, independent data. The independent qualified agent vendor, currently KEPRO, will assess the individual's level of care acuity according to Level of Service Inventory (LSI). OHA examined the LSI data to categorize low intensity level of care needs (LSIs 40 or less), medium intensity (LSIs 41-60), and high intensity (LSIs 61 plus). Based upon provider feedback, OHA worked with Optumas to develop an additional tier for complex need individuals exceeding LSI 79.

OHA is working with Optumas to examine variation, if any, in LSIs between the IQA and the provider, and to establish a baseline to monitor for LSI scoring inflation.

How is this going to affect providers when we have people leave with a high tier and come in with a low tier which would result in possible layoffs or influx in staffing needs and ratios?

OHA worked with the early adopter providers and will monitor implementation for fiscal and operational impacts of the rates and the staffing assumptions for engaging individuals for stabilization and skills building for individuals to be able to transition to more integrated community settings.

The individual's daily care is based on a 24-hour period of active engagement hours and supervision hours, which accounts for the staff providing the active engagement or supervision. The hired staff should be budgeted accordingly based on the funds provided for the daily tier rate. The project team has based staffing assumptions on the operating budgets and GL information submitted to JVGA for analysis.

Does this consider the new SRTF admission criteria which calls for higher acuity in secures?

The general ledger data supports using a single Brick for this service as cost profiles for the different provider types did not differ, nor were there outliers. The acuity and staffing assumptions include higher acuity populations, including individuals in SRTFs and other specialized programs.

Will there be any differences in how non-secure vs. secure rates will be determined?

General ledger analysis did not indicate a difference in costs across different provider types.

OHA re-examined with Optumas whether any required staffing variations for SRTFs and YAT programs were absent from the general ledger data; OHA worked with provider feedback and data adjust rate assumption impacts specific to SRTFs and YAT programs.

Has the LSI been proven to have statistical validity so that it can be used as a rate determinant?
Oregon currently uses the LSI assessment tool across the residential system. Relying upon the IQA's conflict-free LSI assessment also addresses the inter-rater reliability across multiple providers.

Is a provider able to submit a new LSI to establish a new rate whenever there is either an increase in individual needs or a decrease in individual needs resulting in a change in funding?

While OHA assumes LSI changes will be infrequent, OHA looks forward to learning more about the frequency and duration of LSI changes and their effect on each facility's billed rates. OHA is monitoring LSI changes and coordinating joint discussions with providers, KEPRO and CMHPs to improve collective understand of the assessment tool. These discussions will inform the IQA transition as well.

OHA will also work with the IQA, currently KEPRO, to monitor Plan of Care authorization changes.

Will there be training modules for The Brick™ method?

OHA has posted a webinar recording about rate development on the project's web page at <http://www.oregon.gov/oha/HSD/OHP/Pages/MH-Rates.aspx>.

Are there specific number of hours of personal care service per day for each Tier?

Per OAR 410-172-0705:

(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;

Did the Tier scores change for Tier 1-4 then?

Per OAR 410-172-0705:

(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 adult 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:

Mental health residential rehabilitation services

Would rehabilitation treatment services be paid for separately or included in this rate?

Residential services currently include direct care support and billed with code T1020. Mental Health rehabilitation services are provided separately and billed separately. That will continue but not in a per diem rate. Individual rehabilitative codes will be required as of July 1, 2019. The per diem rehabilitative codes will no longer be authorized.

You say this is rate setting for per diem rates. What about those of us who do Fee for Service? Will services get an increase in pricing? Or will they get General Fund/Rent Subsidy be increased?

The fee-for-service residential rate for direct care is billed with code T1020, which is a per day or per diem rate. The new standardized rate will continue to be billed as T1020 as per diem.

The General Fund rent subsidy ended as the program costs are included in the general ledger analysis of program costs and the tiered rate will be applied to OHP and non-OHP resident individuals.

Please explain if all programs are going to be reimbursed via per diem AND rehab treatment costs?

Residential services currently include direct care support and are billed with code T1020 at a per diem rate. That continues. Mental Health rehabilitation services are provided separately and billed separately. That continues. OHA has reviewed rehab services billed as a bundled per diem; these services will no longer be bundled but billed through individual codes.

What about individuals that need 1-on-1 safety supervision for an extended period?

The LSI assessment incorporates the need for 1:1 supervision in the services and supports domain 4. The acuity and staffing assumptions include higher acuity populations, including individuals in SRTFs and other specialized programs. Feedback from early adopters, and provider engagement with other specialized programs helped OHA validate rate assumptions and adjust where data indicated for finalized rates.

How do standardized rates affect billing for HK rehabilitation services?

Residential direct care (personal care and habilitation services in support of individuals' ADLs and 2 IADLs) are covered under T1020 billing, as listed in the Behavioral Health Fee Schedule.

Rehabilitation services are billed separately from the standardized residential services rate.

Can the provider, CMHP or outpatient provider continue billing rehab per diem (H2013 and H2018)?

For providers certified to perform and bill mental health rehabilitation services, CMHPs and outpatient providers treating resident individuals, OHA requires the rehabilitation provider to bill individual treatment services, not the rehab per diem billing.

For sites that have a mental health license is the bundling for services going to look different?

For providers certified to perform outpatient rehabilitative services either onsite or in an outpatient clinic, those services are not a part of the T1020 residential services under the new standardized rates.

However, performing mental health rehabilitative services with resident individuals will require billing individual services, not bundled per diem, to ensure engagement activities are distinct from rehabilitation services.

For CMHPs and contractors performing HK rehabilitation services, will they be able to do so in the future? What will outpatient case management services for a provider that does not have a mental health license look like?

Outpatient rehabilitation services are billed separately from the T1020 residential services covered by the new standardized rates.

OHA is requiring the rehabilitation services to be billed as individual service, not bundled as per diem to understand and ensure engagement activities are distinct from rehabilitation services.

On the new authorization we must list all the codes?

Yes, list individual codes for which prior authorization is required. Refer to the Behavioral Health fee schedule.

Retainer Payment (formerly Reserved Service Capacity payment)

OAR 410-172-0705 (21) For temporary absence 30 days or less.

- Requires notice to OHA in MMIS through a Prior Authorization with attached Retainer Payment form within two business days.
- Medicaid MMIS submission: Medicaid eligible individuals for medical/behavioral/cognitive treatment/hospitalization.
- Invoice Tracker for non-Medicaid individuals, and for non-Medicaid reasons (legal, non-Medicaid absence)
- MH rehab services with individual during temporary absence may be billed separately if indicated, and included in treatment plan to extent applicable

What is the RSCP amount going to be?

The RSCP process has changed to Retainer Payment. The Retainer Payment will be billed and paid at a Tier 1 rate.

For vacancies do providers get any funds?

There is a 5% vacancy factor included in the brick method.

For vacancies other than the defined RP circumstances of absence for less than 30 days for hospitalization (OAR 309-011-0115), no other Medicaid or Behavioral Health funds are allocated.

If both the retainer payment as well as the vacant bed payment are both billed as tier 1 is 30 days still the maximum number of days for a retainer payment? How should a provider bill after 30 days when the individual is still in hospital and does this effect an individual's placement?

There is no vacant bed payment.

There is a 5% vacancy factor built in to the brick method.

The retainer payment rule states a maximum of 30 days. There have been extreme circumstances where the retainer payment has been used for over 30 days. These requests require documentation for the review committee and recommendation to OHA management.

If you are eliminating RSCPs, will providers bill RSCP as Tier 1 through MMIS?

For Medicaid-eligible individuals experiencing a temporary absence for a medical or psychiatric treatment reason, a provider may request an authorization for a RP, which is required to bill through MMIS.

Medicaid Eligible Client		
Step	Responsible Party	Action
1.	Provider	<p>Within two business days following the acute/respite care admission of an individual in a community residential program or two business days prior to the expiration of a previous approval:</p> <ul style="list-style-type: none"> • Complete the HSD Retainer Payment (RP) form, • Create a Prior Authorization (PA) in MMIS for code T2033, and • Attach the RP form to the PA.
2.	Contracts Unit (FA)	Access MMIS for all "Evaluation" RP PAs received each business day.
3.	Contracts Unit (FA)	Review the RP to determine if it is accurate and complete.
4.	Contracts Unit (FA)	<p>Within one business day review and determine approval/denial of the PA request in MMIS.</p> <ul style="list-style-type: none"> • For denials, update status to "Denied." • For approvals, update status to "Ready to Review."
5.	Provider	<p>Once the individual returns to the residential program, or at the expiration of the approved RP request:</p> <ul style="list-style-type: none"> • Complete the Client Status portion of the RP form, and • Upload to the PA.
6.	Contracts Unit (FA)	Review MMIS for all "Ready to Review" RP PAs
7.	Contracts Unit (FA)	<p>Within one business day review and determine approval/denial of the PA request in MMIS.</p> <ul style="list-style-type: none"> • For denials, update status to "Denied." • For approvals, update status to "Approved."
8.	Provider	Submit claim for payment in MMIS for code T2033 at Tier 1 Rate for the home/facility.

What is an example of a legal jurisdiction reason for tier I billing?

For example, a PSRB individual in OSH waiting for PSRB hearing to approve move to home/facility.

When submitting the PA for the T2033, does the 48-hr. requirement still apply?

2 business days (OAR 309-011-0115).

Submitting a PA for the T2033, do we need a signature from the CMHP prior to entry into MMIS?

No, CMHP is not involved in PAs for RP in MMIS. OHA staff will review these requests.

T2033 still available for up to 7 days for elopement?

No, elopements are only being paid up to 72 hours through Contract invoicing only.

Could 370 time at OSH use the retainer code?

No, they cannot.

The residential provider can submit their own request for T2033, correct?

First, submit the PA with the attached form; once approved then you can submit a claim for payment.

For out of county placements (i.e., a Jackson County resident is placed in a Clackamas County RTF), would the RTF provider be invoicing Jackson County or Clackamas County?

Where the individual resides is the county that should be billing and paying.

If we put the wrong PA Assignment can KEPRO change this if we send a message?

Submit your request to the abh.residentialcapacityreporting@dhsosha.state.or.us email with the subject line: PA Assignment error

We have 2 DMAP numbers. One is used for the facility bed and one is used for our individual services. Which one would we submit the retainer payment auth under?

Facility