Answers to Frequently Asked Questions for APD Case Managers and Other Field Staff

Question 1: ***I cannot open a 512 and/or provider is not receiving payment; is it due to licensing?***

Answer: It may be licensing end date but there could be a variety of issues that may be occurring:

- The license or Medicaid Provider Enrollment Agreement (PEA) or Medicaid credential could be expired – check with Provider Relations Unit at: Provider.ENROLLMENT@dhsoha.state.or.us
- It could be a problem with case coding, integration (WLGR), client paying COS. Be sure to check your suspense list. - Please contact Ada Osuna at ada.osuna@.state.or.us with 512 related issues.

Question 2: ***Is the facility required to keep a Medicaid resident if they spend down and facility has a PEA?***

Answer: Current rules address this issue. Medicaid is payment in full. Once a consumer is in the facility they can only be moved out for the reasons in the licensing rule. Therefore, if a consumer spends down, the provider is a Medicaid enrolled provider, and Medicaid is paying the monthly fee, they cannot be evicted. Please reference:

- RESIDENTIAL CARE AND ASSISTED LIVING FACILITIES 411-054-0080 Involuntary Move-out Criteria
- ADULT FOSTER HOMES 411-050-0615 (h) A licensee who elects to provide care for individuals eligible for Medicaid services is not required to admit more than one resident eligible for Medicaid services. However, if the licensee has an approved Medicaid Provider Enrollment Agreement, private-pay residents who become eligible for Medicaid services may not be asked to leave solely on the basis of Medicaid eligibility.

Question 3: ***Can the facility can ask for additional payment from a resident or family for any additional services?***

Answer: According to OAR 411-015-0008, Medicaid payment is payment in full. A facility cannot charge Medicaid residents for any services required in OARs including all services related to ADLs and IADLs. However, facilities can, and often do, charge for extra services like a hairdresser, cable, etc.

Question 4: ***Can a facility charge a pet deposit to a Medicaid resident?***

Answer: Medicaid funds ADL and IADL services, and pet fees are *not* considered ADL or IADL services. Additionally, providers may not treat Medicaid consumers differently than private pay residents. Therefore, if a facility does not charge private pay residents pet fees, they cannot charge Medicaid consumers pet fee. If a facility does charge a pet fee for private pay consumers, the facility may charge the same amount (or less) to Medicaid consumers. Additionally, the facility must disclose these fees on the residency agreements PRIOR to the consumer moving in.

Question 5: ***What does Medicaid pay for in a licensed facility?***

Answer: Medicaid covers all core services in the licensing rules (411-050 and 411-054) including all ADLs and IADLs.

- If the services are expected in the licensing OARs, the providers are expected to meet the assessed needs of the individuals and provider all of the services in the licensing OARs.
- APD may pay for some ancillary services defined in 411-035, such as assistive devices.
- For medical coverage questions, contact the specific CCO or OHA HSD at 1-800-273-0557 for FFS consumers.

Question 6: ***Can we get an OIM (Other Incurred Medical) for a particular item or service or should the facility pay for it? For example: A consumer has skin allergies and needs special laundry detergent. Who pays? When case managers referred them to the Medicaid policy analyst at CO for an answer, they refer the CM back to us.***

Answer: Providers must cover all the services that are required in their licensing OAR. If the service is required per rule (food, all ADL and IADL services), an OIM is not appropriate. It is the responsibility of the provider. In the example provided, since the provider is supposed provide laundry services and they must meet the service needs of the individual, the facility should provide the laundry soap. Please refer to OAR 411-054-0030:

- The residential care or assisted living facility must provide a minimum scope of services as follows:
    - (b) Personal and other laundry services;
- Other issues like this should also be handled according to the licensing rules. If the expectation is that the facility provides the services, then they need to provide all of the components.
- To have a special need covered by the facility, the consumer must disclose any special needs prior to admission (e.g., needs gluten free). If this is about choice or preference, not need, then the provider does not need to meet that want and an OIM is not appropriate.
- If the need is outside the scope of the licensing rules, OIM may be an option.
    - OIM should not be used for Lifeline or other Emergency Response Systems in CBC settings.
- For licensing questions, please contact the APD CBC Licensing:
  Email: cbc.team@state.or.us
  Phone: 503-373-2227
- If after reviewing the licensing rules, there are still questions about OIM, please email: APD.MedicaidPolicy@dhsoha.state.or.us.

Question 7: ***Who should we call to ask questions about paying the CBC Room and Board or the NF portion when someone is in skilled facility?***

Answer: Please email APD.MedicaidPolicy@dhsoha.state.or.us. Please do not refer these questions to licensing.

Question 8: ***Should the resident still pay CBC Room and Board when they are in a skilled facility for rehab?***

Answer: No, the consumer does not need to pay Room and Board when they are not in the facility.

- Room and board payments may be paid to the community-based care facility during the temporary absence of a client if all of the following criteria are met:
    - The absence occurs because the client is admitted to a hospital or nursing home.
    - The Department determines the intent of the client to return to the community-based care facility.
    - The community-based care facility is willing to accept the room and board payment.
    - The client returns within the calendar month following the month in which the absence began.
    - The client may be eligible for the Community Based Care Special Need payment
    - OAR 461-155-0630 (3)(b): https://apps.state.or.us/cf1/caf/arm/B/461-155-0630.htm
    - If you have additional questions, email: APD.MedicaidPolicy@dhsoha.state.or.us

Question 9: ***If the facility gives a resident a move out notice, who is responsible for finding a new placement for the person? Is it the case manager or the provider?***

- The client or representative is required to find placement. The CM may assist with finding new placement.
- If the consumer is unable to locate their own placement and has no representative/family to assist, the CM **should** take the lead in finding a place for the consumer to receive services.

- Contact the Long-Term Care Services & Case Management Policy on the APD CM Tools Website http://www.dhs.state.or.us/spd/tools/cm/ or email APD.MedicaidPolicy@dhsoha.state.or.us.

Question 10: ***Can the facility charge for wipes, gloves, briefs? This is the medical card domain. If the resident runs out of supplies, the facility still has to keep them clean and dry, but they should not be required to provide this month after month.***

- The provider should work with the health plan to get additional supplies.
- It's not an expectation that the CM or HSS3 know or provide this information. They will refer the client/rep to contact the specific CCO or HSD at 1-800-273-0557 for FFS clients.
- 410-122-0630 – Incontinent Supplies
- (1) The Division of Medical Assistance Programs (Division) may cover incontinent supplies for urinary or fecal incontinence as follows:
- (a) Category I Incontinent Supplies: For up to 200 units (any code or product combination in this category) per month, unless documentation supports the medical appropriateness for a higher quantity. For quantities over this limit a prior authorization shall be required. When requesting multiple Category I product types (i.e., diapers and liners) that exceed the allowable, prior authorization and documentation as described in (4)(a)(D) of this rule are required

Question 11: ***If a resident is out of the facility for over 24 hours, when do you start counting and when do you end in order to close the 512? Providers ask the same question, too.***

Answer: If an individual is absent from a community-based care facility for more than 24 hours, staff should close the 512 for the period of the absence.

- For example, if a consumer leaves the facility on 6/6/18 @ 9 am and comes back to the facility on 6/7/18 at 10

pm. We will close the 512 on 6/5/18 and reopen on 6/7/18.

Question 12: ***Can case managers do OIM payments for moneys owed for non-payment of charges while a private pay resident was spending down to Medicaid. Is that OK?***

Answer: Yes, we allow OIMs for payments on past-due bills from a nursing facility or community-based facility during a period a client was not on Medicaid. For amounts owed to a CBC, allowable costs only include the service portion; if the CBC can or will not itemize or break down the room and board amount from the service amount, then deduct the current Medicaid CBC room and board amount (currently $570) to determine the allowable deduction. Please reference: http://www.dhs.state.or.us/spd/tools/program/osip/e.htm#06

However, medical expenses incurred while serving a DQ (disqualification) for a transfer of assets per OAR 461-160-0030(2)(e): The following costs are not deductible: …… In the OSIPM program, a cost that the client incurred while the client was serving a disqualification from Medicaid under OAR 461-140-0210 to 461-140-0300 for a transfer of assets for less than fair market value.

Question 13: ***Can a facility charge a Medicaid resident for costs incurred for repairs due to damage caused by the resident?***

Answer: No, facilities cannot charge a Medicaid resident any additional money beyond their monthly room and board and liability portion (if any) as indicated on their current 512.