# Frequently Asked Questions Regarding Consumers in Facilities for Case Managers and Local Office Staff

**(Revised 09/2023)**

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

CMs and LO staff should go to the APD Training page (https://dhsoha.sharepoint.com/teams/Hub-ODHS-APD-Staff-Tools/SitePages/Training-and-Events.aspx#apd-training) where they will find the 512 Troubleshooting tool.

CMs/LO Staff should check the PRV8 for active/inactive provider information.

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

- Staff should be able to see the provider in Oregon ACCESS (OA). You will get an error on the SMSG screen.
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If the provider number is inactive, this means that the license or Medicaid Provider Enrollment Agreement (PEA) could be expired. Please email Provider Relations Unit at: Provider.ENROLLMENT@dhsoha.state.or.us and request status. It is likely the update to the provider number is in process and the provider number can generally be updated the same day.

***Question 2: Is the facility required to keep a Medicaid resident and not issue a move-out notice if the resident spends down and facility is enrolled as a Medicaid provider?***

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, the consumer cannot be moved out/evicted. Please reference: RESIDENTIAL CARE AND ASSISTED LIVING FACILITIES OAR 411-054-0080 Involuntary Move-out Criteria.

Providers are allowed to end their Medicaid contracts with specific advance notification to the Provider Relations Unit and local office and upon approval of agreed termination of the Provider Enrollment Agreement, then the provider must give

specific advance notification to consumers that they will no longer be accepting Medicaid as if the agreed upon date.
ADULT FOSTER HOMES OAR 411-050-0705 Residency Agreement

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

According to OAR 411-015-0008(2)(e), 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?***

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?***

Medicaid covers all core services in the licensing rules (OAR 411-050 and OAR 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 OAR 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.***

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. That service is the responsibility of the provider. In the example provided, since the provider is required to provide laundry services, they must meet the service needs of the individual, the facility should provide the laundry appropriate soap. Please refer to OAR 411-054-0030.

The residential care or assisted living facility must provide a minimum scope of services as follows:

- (1)(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.
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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.

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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?***

Please email APD.MedicaidPolicy@dhsoha.state.or.us (Please do not refer these questions to licensing). For licensing questions for CBC facilities please contact the Policy Analyst at CBC.Team@odhsoha.oregon.gov.

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

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

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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* ((OAR 461-155-0630(2)(b)):

- 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.

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The client may be eligible for the Community Based Care Special Need payment:
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 provider is not responsible to find new placement for the resident. If the person is being evicted for dangerous behaviors perhaps the case manager should make a referral to complex case as soon as they get the move out notice.

The client or their 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. If the person is being evicted for dangerous behaviors the CM should make a referral to complex case as soon as the consumer receives a move out notice.

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 eligibility worker know or provide this information. They will refer the consumer or their representative to contact the specific CCO or HSD at 1-800-562-4620 for FFS clients.

The consumer should be working with their doctors/PCPs. OAR 410-122-0630(1)(a) – Incontinent Supplies

***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.***

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 06/06/23 at 9 a.m. and comes back to the facility on 06/07/23 at 10 p.m. We will close the 512 on 06/05/23 and reopen on 06/07/23.

***Question 12: Can Eligibility workers (EW) enter OIM payments into the ONE system for moneys owed for non-payment of charges while a private pay resident was spending down to Medicaid. Is that OK?***

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: OAR 461-155-0270.

- Case managers no longer do OIMs. Eligibility workers would enter them into the ONE system
- 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.
- We would not allow for an OIM for these, if the individual was serving a DQ.

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

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.