

Secretary of State
Certificate and Order for Filing
PERMANENT ADMINISTRATIVE RULES

I certify that the attached copies are true, full and correct copies of the PERMANENT Rule(s) adopted on Upon filing, by the

Department of Human Services, Aging and People with Disabilities and Developmental Disabilities 411
Agency and Division Administrative Rules Chapter Number
Kimberly Colkitt-Hallman (503) 945-6398
Rules Coordinator Telephone
500 Summer St. NE, E48, Salem, OR 97301
Address

To become effective 04/01/2014 Rulemaking Notice was published in the January 2014 Oregon Bulletin.

RULE CAPTION

Nursing Facility Capacity Reduction

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

RULEMAKING ACTION

Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

ADOPT:

411-070-0437

AMEND:

411-070-0005, 411-070-0300, 411-070-0442

REPEAL:

411-070-0005(T), 411-070-0300(T), 411-070-0437(T), 411-070-0442(T)

RENUMBER:

AMEND AND RENUMBER:

Statutory Authority:

ORS 410.070; ORS 414.065

Other Authority:

HB 2216 (2013); OL 2013 Chapter 608

Statutes Implemented:

ORS 410.070; ORS 414.065

RULE SUMMARY

The Department of Human Services (Department) is permanently updating the rules in OAR chapter 411, division 070 for Medicaid nursing facilities to make permanent temporary rule language that became effective on October 7, 2013 to implement HB 2216 (2013) which directs the Department to implement a nursing facility capacity reduction.

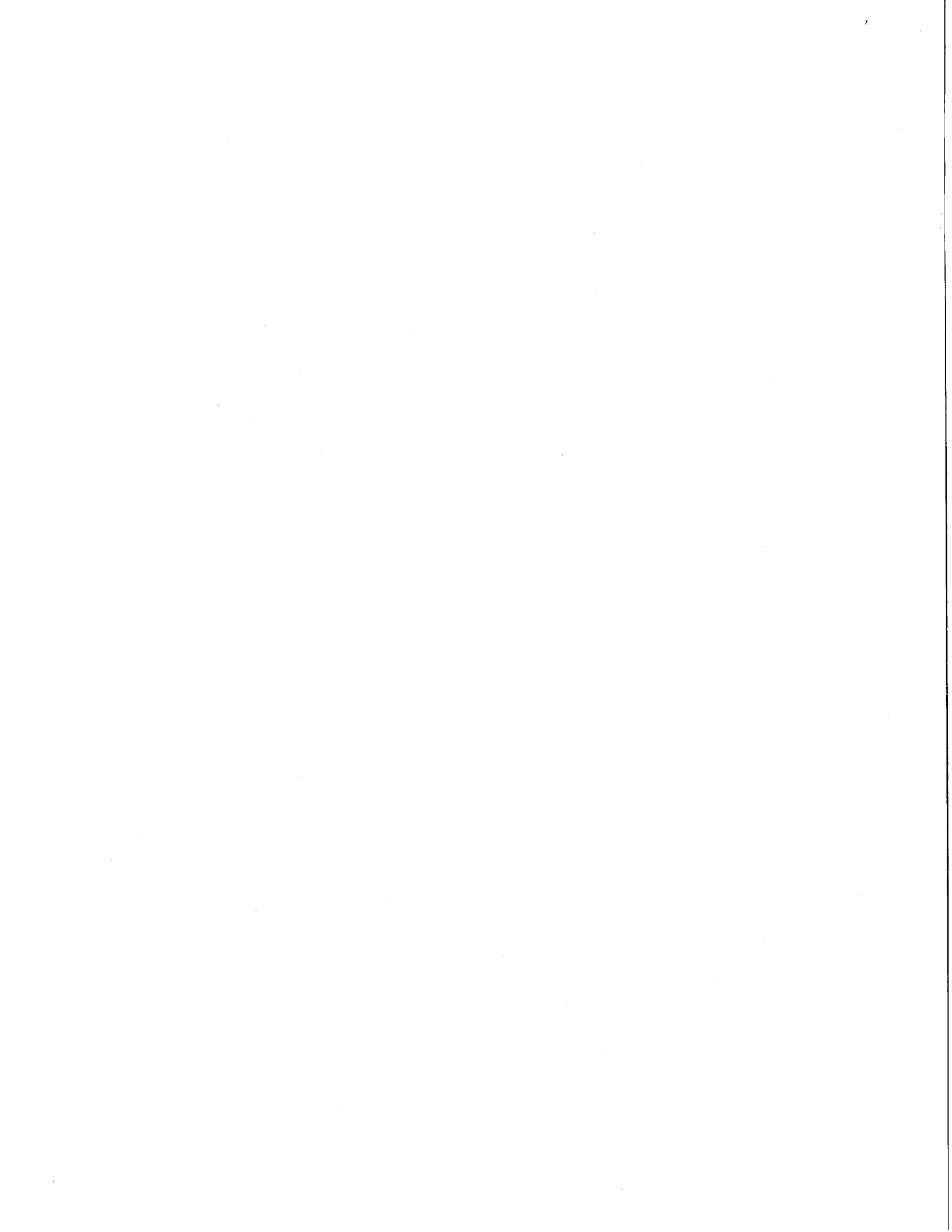
The permanent rules:

- Establish a statewide bed reduction target for nursing facilities to bring Oregon's occupancy rate closer to the national level;
- Provide an augmented rate for nursing facilities that purchase beds from nursing facilities that are no longer needed;
- Reduce nursing facility reimbursement rates if identified reduction targets are not achieved;
- Authorize annual rebasing of the nursing facility rate; and
- Extend the Nursing Facility Financial Statement deadline to October 31 of each year with no extensions.

Kimberly Colkitt-Hallman
Rules Coordinator Name

kimberly.colkitt-hallman@state.or.us
Email Address

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PERMANENT ADMINISTRATIVE RULES

Department of Human Services, Aging and People with
Disabilities and Developmental Disabilities

411

Agency and Division

Administrative Rules Chapter Number

Christina Hartman

christina.hartman@state.or.us

Rules Coordinator

Email Address

500 Summer St. NE, Salem, OR 97301-1074

503-945-6398

Address

Telephone

Upon filing.

Adopted on

04/01/2014

Effective date

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Michael McCornick

3/2/14

Authorized Signer

Printed Name

Date

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

DIVISION 70
NURSING FACILITIES/MEDICAID – GENERALLY AND REIMBURSEMENT
Nursing Facilities/Medicaid – Generally

411-070-0005

Definitions

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-085-0005 apply to the rules in OAR chapter 411, division 070:

- (1) "Accrual Method of Accounting" means a method of accounting in which revenues are reported in the period when they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.
- (2) "Active Treatment" means the implementation of an individualized care plan developed under and supervised by a physician and other qualified mental health professionals that prescribes specific therapies and activities.
- (3) "Activities of Daily Living" means activities usually performed in the course of a normal day in an individual's life such as eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition/behavior.
- (4) "Addictions and Mental Health (AMH) Division" means the Division, within the Oregon Health Authority, responsible for addictions and mental health services.
- (5) "Alternative Services" mean individuals or organizations offering services to persons living in a community other than a nursing facility or hospital.
- (6) "Area Agency on Aging (AAA)" means the Department of Human Services designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors and individuals with disabilities in a planning and service area. For the purpose of these rules, the term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300.
- (7) "Augmented Rate" means the additional compensation to a nursing facility who qualifies for the Quality and Efficiency Incentive Program described in OAR 411-070-0437. The augmented rate is a daily rate of \$9.75 and is in addition to the rate that a nursing facility would otherwise receive. The Department may pay the augmented rate to a qualifying facility for a period not to exceed four years from the date that the facility purchases bed capacity under the Quality and Efficiency Incentive Program.
- (8) "Basic Flat Rate Payment" and "Basic Rate" means the statewide standard payment rate for all long term services provided to a Medicaid resident of a nursing facility except for services reimbursed through another Medicaid payment source. The "Basic Rate" is the bundled payment rate unless the resident qualifies for the complex medical add-on rate (in addition to the basic rate) or the bundled pediatric rate (instead of the basic rate).
- (9) "Capacity" means licensed nursing beds multiplied by number of days in operation.
- (10) "Case Manager" means a Department of Human Services or Area Agency on Aging employee who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements the service plan and monitors the services delivered.
- (11) "Cash Method of Accounting" means a method of accounting in which revenues are recognized only when cash is received, and expenditures for expense and asset items are not recorded until cash is disbursed for them.
- (12) "Categorical Determinations" mean the provisions in the Code of Federal Regulations {42 CFR 483.130} for creating categories that describe certain diagnoses, severity of illness, or the need for a particular service that clearly indicates that admission to a nursing facility is normally needed or that the provision of specialized services is not normally needed.
 - (a) Membership in a category may be made by the evaluator only if existing data on the individual is current, accurate, and of sufficient scope.
 - (b) An individual with mental illness or developmental disabilities may enter a nursing facility without PASRR Level II evaluation if criteria of a categorical determination are met as described in OAR 411-070-0043(2)(a)-(2)(c).
- (13) "Certification" and "Certification for the Categorical Determination of Exempted Hospital Discharge" means that the attending physician has written orders for the individual to receive skilled services at the nursing facility.
- (14) "Certified Program" means a hospital, private agency, or an Area Agency on Aging certified by the Department of Human Services to conduct private admission assessments in accordance with ORS 410.505 through 410.530.
- (15) "Change of Ownership" means a change in the individual or legal organization that is responsible for the operation of a nursing facility. Change of ownership does not include changes that are merely changes in personnel, e.g., a change of administrators. Events that change ownership include but are not limited to the following:
 - (a) The form of legal organization of the owner is changed (e.g., a sole proprietor forms a partnership or corporation);
 - (b) The title to the nursing facility enterprise is transferred to another party;
 - (c) The nursing facility enterprise is leased or an existing lease is terminated;
 - (d) Where the owner is a partnership, any event occurs which dissolves the partnership;

- (e) Where the owner is a corporation, it is dissolved, merges with another corporation that is the survivor, or consolidates with one or more other corporations to form a new corporation; or
- (f) The facility changes management via a management contract.
- (16) "Compensation" means the total of all benefits and remuneration, exclusive of payroll taxes and regardless of the form, provided to or claimed by an owner, administrator, or other employee. Compensation includes but is not necessarily limited to:
- (a) Salaries paid or accrued;
 - (b) Supplies and services provided for personal use;
 - (c) Compensation paid by the facility to employees for the sole benefit of the owner;
 - (d) Fees for consultants, directors, or any other fees paid regardless of the label;
 - (e) Key man life insurance;
 - (f) Living expenses, including those paid for related persons; or
 - (g) Gifts for employees in excess of federal Internal Revenue Service reporting guidelines.
- (17) "Complex Medical Add-On Payment" and "Medical Add-On" means the statewide standard supplemental payment rate for a Medicaid resident of a nursing facility whose service is reimbursed at the basic rate if the resident needs one or more of the medication procedures, treatment procedures, or rehabilitation services listed in OAR 411-070-0091, for the additional licensed nursing services needed to meet the resident's increased needs.
- (18) "Continuous" means more than once per day, seven days per week. Exception: If only skilled rehabilitative services and no skilled nursing services are required, "continuous" means at least once per day, five days per week.
- (19) "Costs Not Related to Resident Services" means costs that are not appropriate or necessary and proper in developing and maintaining the operation of a nursing facility. Such costs are not allowable in computing reimbursable costs. Costs not related to resident services include, for example, cost of meals sold to visitors, cost of drugs sold to individuals who are not residents, cost of operation of a gift shop, and similar items.
- (20) "Costs Related to Resident Services" mean all necessary costs incurred in furnishing nursing facility services, subject to the specific provisions and limitations set out in these rules. Examples of costs related to resident services include nursing costs, administrative costs, costs of employee pension plans, and interest expenses.
- (21) "CPI" means the consumer price index for all items and all urban consumers.
- (22) "Day of Admission" means an individual being admitted, determined as of 12:01 a.m. of each day, for all days in the calendar period for which an assessment is being reported and paid. If an individual is admitted and discharged on the same day, the individual is deemed present on 12:01 a.m. of that day.
- (23) "Department" or "DHS" means the Department of Human Services.
- (24) "Developmental Disability" means a disability that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional. Developmental disabilities include mental retardation, autism, cerebral palsy, epilepsy, or other neurological disabling conditions that require training or support similar to that required by individuals with mental retardation, and the disability:
- (a) Originates before the individual reaches the age of 22 years, except that in the case of mental retardation, the condition must be manifested before the age of 18;
 - (b) Originates and directly affects the brain and has continued, or must be expected to continue, indefinitely;
 - (c) Constitutes a significant impairment in adaptive behavior; and
 - (d) Is not primarily attributed to a mental or emotional disorder, sensory impairment, substance abuse, personality disorder, learning disability, or Attention Deficit Hyperactivity Disorder (ADHD).
- (25) "Direct Costs" mean costs incurred to provide services required to directly meet all the resident nursing and activity of daily living service needs. Direct costs are further defined in OAR 411-070-0359 and OAR 411-070-0465. Examples: The person who feeds food to the resident is directly meeting the resident's needs, but the person who cooks the food is not. The person who is trained to meet the resident's needs incurs direct costs whereas the person providing the training is not. Costs for items that are capitalized or depreciated are excluded from this definition.
- (26) "Division of Medical Assistance Programs (DMAP)" means a Division, within the Oregon Health Authority, responsible for coordinating the medical assistance programs within the State of Oregon including the Oregon Health Plan Medicaid demonstration, the State Children's Health Insurance Program, and several other programs.
- (27) "DRI Index" means the "HCFA or CMS Nursing Home Without Capital Market Basket" index, which is published quarterly by DRI/McGraw - Hill in the publication, "Global Insight Health Care Cost Review".
- (28) "Essential Nursing Facility" means a nursing facility that serves predominantly rural and frontier communities as designated by the Office of Rural Health that is located more than 32 miles from another nursing facility or from a hospital that has received a formal notice of Critical Access Hospital (CAH) designation from the Centers for Medicare and Medicaid Services and that is currently contracted to provide swing bed services for Medicaid-eligible individuals.
- (29) "Exempted Hospital Discharge" for PASRR means an individual seeking temporary admission to a nursing facility from a hospital as described in OAR 411-070-0043(2)(a).

- (30) "Facility" or "Nursing Facility" means an establishment that is licensed and certified by the Department of Human Services as a nursing facility. A nursing facility also means a Medicaid certified nursing facility only if identified as such.
- (31) "Fair Market Value" means the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between a well-informed buyer and seller, neither being under any compulsion to buy or sell.
- (32) "Generally Accepted Accounting Principles" mean the accounting principles approved by the American Institute of Certified Public Accountants.
- (33) "Goodwill" means the excess of the price paid for a business over the fair market value of all other identifiable, tangible, and intangible assets acquired, or the excess of the price paid for an asset over its fair market value.
- (34) "Historical Cost" means the actual cost incurred in acquiring and preparing a fixed asset for use. Historical cost includes such planning costs as feasibility studies, architects' fees, and engineering studies. Historical cost does not include "start-up costs" as defined in this rule.
- (35) "Hospital-Based Facility" means a nursing facility that is physically connected and operated by a licensed general hospital.
- (36) "Indirect Costs" mean the costs associated with property, administration, and other operating support (real property taxes, insurance, utilities, maintenance, dietary (excluding food), laundry, and housekeeping). Indirect costs are further described in OAR 411-070-0359 and OAR 411-070-0465.
- (37) "Individual" means a person who receives or expected to receive nursing facility services.
- (38) "Interrupted-Service Facility" means an established facility recertified by the Department of Human Services following decertification.
- (39) "Level I" means a component of the federal PASRR requirement. Level I refers to the identification of individuals who are potential nursing facility admissions who have indicators of mental illness or developmental disabilities {42 CFR 483.128(a)}.
- (40) "Level II" means a component of the federal PASRR requirement. Level II refers to the evaluation and determination of whether nursing facility services and specialized services are needed for individuals with mental illness or developmental disability who are potential nursing facility admissions, regardless of the source of payment for the nursing facility service {42 CFR 483.128(a)}. Level II evaluations include assessment of the individual's physical, mental, and functional status {42 CFR 483.132}.
- (41) "Level of Care Determination" means an evaluation of the intensity of a person's health service needs. The level of care determination may not be used to require that the person receive services in a nursing facility.
- (42) "Medicaid Occupancy Percentage" means the total Medicaid bed days divided by total resident days.
- (43) "Medical Add-On" or "Complex Medical Add-On Payment" has the meaning provided in section (16) of this rule.
- (44) "Mental Illness" means a major mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV-TR) limited to schizophrenic, paranoid and schizoaffective disorders, bipolar (manic-depressive), and atypical psychosis. "Mental Illness" for pre-admission screening means having both a primary diagnosis of a major mental disorder (schizophrenic, paranoid, major affective and schizoaffective disorders, or atypical psychosis) and treatment related to the diagnosis in the past two years. Diagnoses of dementia or Alzheimers are excluded.
- (45) "Mental Retardation" means significantly sub-average general intellectual functioning defined as IQ's under 70 as measured by a qualified professional and existing concurrently with significant impairment in adaptive behavior that are manifested during the developmental period, prior to 18 years of age. Individuals of borderline intelligence, IQ's 70-75, may be considered to have mental retardation if there is also significant impairment of adaptive behavior as diagnosed and measured by a qualified professional. The adaptive behavior must be directly related to the issues of mental retardation. Definitions and classifications must be consistent with the "Manual of Terminology and Classification in Mental Retardation" by the American Association on Mental Deficiency, 1977 Revision.
- (a) Mild mental retardation is used to describe the degree of retardation when intelligence test scores are 50 to 69. Individuals with IQ's in the 70 to 75 range may be considered as having mental retardation if there is significant impairment in adaptive behavior as defined in OAR 411-320-0020.
- (b) Moderate mental retardation is used to describe the degree of retardation when intelligence test scores are 35 to 49.
- (c) Severe mental retardation is used to describe the degree of retardation when intelligence test scores are 20 to 34.
- (d) Profound mental retardation is used to describe the degree of retardation when intelligence test scores are below 20.
- (46) "Necessary Costs" mean costs that are appropriate and helpful in developing and maintaining the operation of resident facilities and activities. Necessary costs are usually costs that are common and accepted occurrences in the field of long term nursing services.
- (47) "New Admission" for PASRR purposes means an individual admitted to any nursing facility for the first time. It does not include individuals moving within a nursing facility, transferring to a different nursing facility, or individuals who have returned to a hospital for treatment and are being admitted back to the nursing facility. New admissions are subject to the PASRR process {42 CFR 483.106(b)(1), (3), (4)}.
- (48) "New Facility" means a nursing facility commencing to provide services to individuals.
- (49) "Nursing Aide Training and Competency Evaluation Program (NATCEP)" means a nursing assistant training and competency evaluation program approved by the Oregon State Board of Nursing pursuant to ORS chapter 678 and the rules adopted pursuant thereto.

- (50) "Nursing Facility Financial Statement (NFFS)" means Form SPD 35, or Form SPD 35A (for hospital-based facilities), and includes an account number listing of all costs to be used by all nursing facility providers in reporting to the Department of Human Services for reimbursement.
- (51) "Occupancy Rate" means total resident days divided by capacity.
- (52) "Official Bed Count Measurement" means the number of licensed nursing facility beds as of October 7, 2013 and the beds being developed by facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December 1, 2012 or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013.
- (53) "Ordinary Costs" mean costs incurred that are customary for the normal operation.
- (54) "Oregon Medical Professional Review Organization (OMPRO)" means the organization that determines level of services, need for services, and quality of services.
- (55) "Pediatric Rate" means the statewide standard payment rate for all long term services provided to a Medicaid resident under the age of 21 who is served in a pediatric nursing facility or a self-contained pediatric unit.
- (56) "Perquisites" mean privileges incidental to regular wages.
- (57) "Personal Incidental Funds" mean resident funds held or managed by the licensee or other person designated by the resident on behalf of a resident.
- (58) "Placement" means the location of a specific place where health services can be adequately provided to meet the service needs.
- (59) "Pre-Admission Screening (PAS)" means the assessment and determination of a potential Medicaid-eligible individual's need for nursing facility services, including the identification of individuals who can transition to community-based service settings and the provision of information about community-based alternatives. This assessment and determination is required when potentially Medicaid-eligible individuals are at risk for admission to nursing facility services. PAS may include the completion of the federal PASRR Level I requirement {42 CFR, Part 483, (C)-(E)}, to identify individuals with mental illness or mental retardation or developmental disabilities.
- (60) "Pre-Admission Screening and Resident Review (PASRR)" means the federal requirement, {42 CFR, Part 483, (C)-(E)}, to identify individuals who have mental illness or developmental disabilities and determine if nursing facility service is required and if specialized services are required. PASRR includes Level I and Level II functions.
- (61) "Prior Authorization" means the local Seniors and People with Disabilities Division/Area Agency on Aging office participates in the development of proposed nursing facility care plans to assure that the facility is the most suitable service setting for the individual. Nursing facility reimbursement is contingent upon prior-authorization.
- (62) "Private Admission Assessment (PAA)" means the assessment that is conducted for non-Medicaid residents as established by ORS 410.505 to 410.545 and OAR chapter 411, division 071, who are potential admissions to a Medicaid-certified nursing facility. Service needs are evaluated and information is provided about long-term service choices. A component of private admission assessment is the federal PASRR Level I requirement, {42 CFR, Part 483.128(a)}, to identify individuals with mental illness or developmental disabilities.
- (63) "Provider" means an entity, licensed by the Seniors and People with Disabilities Division, responsible for the direct delivery of nursing facility services.
- (64) "Provider Preventable Condition (PPC)" means a condition listed below caused by the provider:
- (a) Foreign object retained after treatment;
 - (b) Stage III and IV pressure ulcers;
 - (c) Falls and trauma;
 - (d) Manifestations of poor glycemic control;
 - (e) Catheter-associated urinary tract infection;
 - (f) Medication error; or
 - (g) Surgical site or wound site infection.
- (65) "Quality and Efficiency Incentive Program" means the program described in OAR 411-070-0437 designed to reimburse quality nursing facilities that voluntarily reduce bed capacity that increases occupancy levels and enhances efficiency with the goal of slowing the growth of system-wide costs.
- (66) "Reasonable Consideration" means an inducement that is equivalent to the amount that would ordinarily be paid for comparable goods and services in an arms-length transaction.
- (67) "Related Organization" means an entity that is under common ownership or control with, or has control of, or is controlled by the contractor. An entity is deemed to be related if it has 5 percent or more ownership interest in the other. An entity is deemed to be related if it has capacity derived from any financial or other relationship, whether or not exercised, to influence directly or indirectly the activities of the other.
- (68) "Resident" means a person who receives nursing facility services.
- (69) "Resident Days" mean the number of occupied bed days.

- (70) "Resident Review" means a review conducted by the Addictions and Mental Health Division for individuals with mental illness or by the Seniors and People with Disabilities Division for individuals with developmental disabilities who are residents of nursing facilities. The findings of the resident review may result in referral to PASRR Level II {42 CFR 483.114}.
- (71) "Restricted Fund" means a fund in which the use of the principal or principal and income is restricted by agreement with or direction by the donor to a specific purpose. Restricted fund does not include a fund over which the owner has complete control. The owner is deemed to have complete control over a fund that is to be used for general operating or building purposes.
- (72) "Seniors and People with Disabilities (SPD) Division" means the Department.
- (73) "Specialized Services for Mental Illness" means mental health services delivered by an interdisciplinary team in an inpatient psychiatric hospital for treatment of acute mental illness.
- (74) "Specialized Services for Mental Retardation or Developmental Disabilities" means:
- (a) For individuals with mental retardation or developmental disabilities under age 21, specialized services are equal to school services; and
 - (b) For individuals with mental retardation or developmental disabilities over age 21, specialized services mean:
 - (A) A consistent and ongoing program that includes participation by the individual in continuous, aggressive training and support to prevent loss of current optimal function;
 - (B) Promotes the acquisition of function, skills, and behaviors necessary to increase independence and productivity; and
 - (C) Is delivered in community-based or vocational settings at a minimum of 25 hours a week.
- (75) "Start-Up Costs" mean one-time costs incurred prior to the first resident being admitted. Start-up costs include administrative and nursing salaries, utility costs, taxes, insurance, mortgage and other interest, repairs and maintenance, training costs, etc. Start-up costs do not include such costs as feasibility studies, engineering studies, architect's fees, or other fees that are part of the historical cost of the facility.
- (76) "Supervision" means initial direction and periodic monitoring of performance. Supervision does not mean that the supervisor is physically present when the work is performed.
- (77) "These Rules" mean the rules in OAR chapter 411, division 070.
- (78) "Title XVIII" and "Medicare" means Title XVIII of the Social Security Act.
- (79) "Title XIX," "Medicaid," and "Medical Assistance" means Title XIX of the Social Security Act.
- (80) "Uniform Chart of Accounts (Form SPD 35)" means a list of account titles identified by code numbers established by the Department of Human Services for providers to use in reporting their costs.
- Stat. Auth.: ORS 410.070
 Stats. Implemented: ORS 410.070 & ORS 414.065

411-070-0300

Filing of Financial Statement

- (1) The provider must file annually with the Department, Financial Audit Unit, the Nursing Facility Financial Statement (NFFS) covering actual costs based on the facility's fiscal reporting period for the period ending June 30. A NFFS must be filed for other than a year only when necessitated by termination of a provider agreement with the Department, or by a change in ownership, or when directed by the Department. Financial reports containing up to 15 months of financial data are accepted for the reasons above or with the Department's permission prior to filing.
- (2) A NFFS is due on or before October 31 or within three months of a change of ownership or withdrawal from the program.
 - (a) A NFFS must be postmarked on or before the due date to be considered timely. An extension may not be obtained.
 - (b) A penalty is assessed and collected when a NFFS is not postmarked within the due date. The amount of the penalty is \$5 per licensed nursing facility bed per day for each State of Oregon business day the NFFS is late. The total penalty may not exceed \$50,000 per fiscal reporting period. For purposes of this section, the number of licensed nursing facility beds is the number of beds licensed on the last day of the fiscal reporting period that the facility failed to submit a NFFS.
 - (c) The Department may assess interim penalties and deduct the amount of the interim penalties from the next Medicaid payment payable to the facility. Each interim penalty is the amount of the penalty that has accrued under subsection (2)(b) of this section to the date of assessment, and has not already been assessed as an interim penalty.
 - (d) A facility may request an informal conference or contested case hearing pursuant to ORS 183.413 through 183.470 within 30 days of receiving a letter from the Department informing the facility of assessment of an interim penalty or a penalty under this rule. OAR 411-070-0435 applies to such requests and sets forth the procedures to be followed. If no request for an informal conference or contested case hearing is made within 30 days of receiving such a letter, the interim penalty or penalty becomes final in all respects, including liability for payment of and the amount of the interim penalty or penalty.
- (3) An improperly completed or incomplete NFFS is returned to the facility for proper completion.
- (4) FORMS.
 - (a) Form SPD 35 is a uniform cost report to be used by all nursing facility providers, except those that are hospital based.
 - (b) Form SPD 35A is a uniform cost report to be used by all nursing facility providers that are hospital based.

(c) Forms SPD 35 and SPD 35A must be completed in accordance with the Medicaid Nursing Facility Services Provider Guide and Audit Manual.

(5) If a provider knowingly or with reason to know files a NFFS containing false information, such action constitutes cause for termination of its agreement with the Department. Providers filing false reports may be referred for prosecution under applicable statutes.

(6) Each required NFFS must be signed by a company or corporate officer or a person designated by the corporate officers to sign. If a NFFS is prepared by someone other than an employee of the provider, the individual preparing the NFFS must also sign and indicate his or her status with the provider.

(7) Facilities with fewer than 1000 Medicaid resident days during a twelve-month reporting period or fewer than 2.74 Medicaid resident days per calendar day, for facilities with reporting periods of less than a year, are not required to submit a SPD 35 or SPD 35A but must submit a letter to the Department indicating the nursing facility is not submitting a NFFS. This letter is due the same day a NFFS would have been due.

(8) A NFFS must be filed annually by each facility for the fiscal reporting period that ends June 30. The NFFS filed for the period that ends June 30 is required to cover actual costs during the previous state fiscal year from July 1 through June 30.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070 & OL 2013 chapter 608

411-070-0437

Quality and Efficiency Incentive Program

(1) ESTABLISHMENT. Effective October 7, 2013 through December 31, 2015, the Department establishes the Quality and Efficiency Incentive Program (Program) in order to implement Enrolled House Bill 2216 (Chapter 608, 2013 Oregon Laws). The Program is designed to reimburse quality nursing facilities that voluntarily reduce bed capacity that increases occupancy levels and enhances efficiency with the goal of slowing the growth of system-wide costs. The Department may provide additional compensation to nursing facilities who qualify for the legislatively approved Program. Such compensation may not exceed \$9.75 per resident day and may not exceed four years from the date of eligibility. Eligibility to participate in this Program sunsets on December 31, 2015.

(2) CAPACITY REDUCTION DISCUSSIONS. If two or more providers wish to initiate discussions concerning reduction of bed capacity in a community, the providers must notify the Department. The notice must identify the community and state that the parties wish to discuss reduction of bed capacity in that market pursuant to the Program.

(a) Upon receipt of a notice to discuss reduction of bed capacity, the Department shall review the notice and either approve or disapprove the proposed preliminary discussion. The Department shall approve the preliminary discussion if the community is one in which the proposed capacity reduction is consistent with the goals of the Program.

(b) If the Department approves the preliminary discussion, the Department shall notify the providers who requested approval and shall schedule a meeting at which a Department representative shall be made available to supervise the discussion. Providers in the affected market may attend the meeting and may discuss capacity reduction for that market under the supervision of the Department.

(c) The Department shall determine the time, place, and mechanism to discuss the reduction of bed capacity. The discussions may be held in-person or by means of conference call, video conference, or such other means that allow for each participant to hear and be heard by the other participant at the same time.

(d) Notice to the Department is not required for two providers who wish to discuss a specific transfer of bed capacity.

(3) CAPACITY REDUCTION TRANSACTIONS. Prior to any purchase of bed capacity under the Program, the parties to the transaction must notify the Department.

(a) The notice must describe the parties, the specific facilities, the proposed transaction, and the acquisition plan for the transaction.

(b) The acquisition plan must include documentation demonstrating that:

(A) The purchasing operator is able to meet or arrange for the needs of the individuals residing in the selling facility and meet all change of ownership or operator and closure criteria as described in OAR 411-085-0025;

(B) The selling operator meets the eligibility criteria described in section (5) of this rule and meets the criteria for nursing facility closure described in OAR 411-085-0025;

(C) Bed capacity in the community shall be reduced as a result of the transaction; and

(D) The transaction does not compromise care or health status of residents.

(c) The Department may approve the acquisition plan, disapprove the acquisition plan, or request further information or changes in the acquisition plan. The Department shall approve the transaction upon finding that the acquisition plan is expected to satisfy conditions (A) through (D) in subsection (b) of this section. If the Department approves or disapproves the transaction, the Department shall issue an order approving or disapproving the transaction and explaining how conditions (A) through (D) in subsection (b) of this section are satisfied or not satisfied.

(d) The purchasing operator may receive incentives under the Program only if the Department approves the transaction and the purchasing and selling operators complete the transaction as described in the acquisition plan. The purchasing operator and selling operator are entitled to state action antitrust immunity for the transaction only if the Department approves the transaction.

(e) Once approved for participation in the Program, the selling facility must provide all notices and meet the other requirements of a facility closure under OAR 411-085-0025, including limiting admissions of residents to the facility.

(4) COMMUNITY TRANSITION MEETING.

(a) The Department, in consultation with the Long Term Care Ombudsman, shall convene a regional planning meeting in communities in which a facility plans to surrender the facility's license under these rules. The meeting shall engage the community in:

- (A) Planning to promote the safety and dignity of residents who shall be impacted by the surrender;
- (B) A discussion regarding the local need for more home and community-based settings; and
- (C) Assessing opportunities for more residential programs and supporting residential capacity.

(b) The Community Transition Meeting is initiated by the Department upon approval of an acquisition as described in this rule.

(5) ELIGIBILITY. The eligibility requirements for participation in the Program are:

- (a) The nursing facility bed capacity being sold (the "selling facility") is not an Essential Nursing Facility or from a facility operated on behalf of the Oregon Department of Veteran's Affairs; and
- (b) The selling facility's entire bed capacity is purchased and the seller agrees to surrender the nursing facility's license on the earlier of the date that:

- (A) The last resident is transferred from the facility; or
- (B) 180 days after the effective date of the sale of the facility bed capacity.

(c) A Program applicant (the "purchasing operator") must meet all of the following criteria at the time of the acquisition plan submission:

- (A) Operate one or more facilities licensed by the Department as a nursing facility;
- (B) Must be determined to be in substantial compliance from the annual licensing and recertification survey at the date of the acquisition plan submission; and
- (C) Have no substantiated facility abuse meeting the criteria in ORS 441.715(2)(c) within six months of the date of the acquisition plan submission.

(d) The selling facility must provide all notices and meet the requirements of a facility closure under OAR 411-085-0025.

(6) ANTITRUST PROVISION.

(a) The Department declares its intent to exempt from state antitrust laws and provide state action immunity from federal antitrust laws individuals and entities that engage in transactions, meetings, or surveys described in sections (2) and (3) of this rule that might otherwise be constrained by such laws.

(b) The following activities are not immunized from antitrust liability:

- (A) Agreements among competing providers to reduce the number of beds they operate outside of a sale;
- (B) Provider meetings to discuss bed reduction strategies outside of the negotiation of a specific sale and where no Department representative is in attendance; or
- (C) Collateral agreements between competing providers that involve their pricing strategies, how to respond to requests for proposals, or other discussions outside the sale of facilities.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070 & OL 2013 chapter 608

411-070-0442

Calculation of the Basic Rate and Complex Medical Add-on Rate

(1) The rates are determined annually and referred to as the Rebasing Year.

(a) The basic rate is based on the statements received by the Department by October 31 for the fiscal reporting period ending on June 30 of the previous year. For example, for the biennium beginning July 1, 2013, statements for the period ending June 30, 2012 are used. The Department desk reviews or field audits these statements and determines the allowable costs for each nursing facility. The costs include both direct and indirect costs. The costs and days relating to pediatric beds are excluded from this calculation. The Department only uses financial reports of facilities that have been in operation for at least 180 days and are in operation as of June 30.

(b) For each facility, its allowable costs are applied, less the costs of its self-contained pediatric unit (if any) is inflated from the mid-point of its fiscal reporting period to the mid-point of the first year of the biennium, hereafter referred to as the base year (e.g., for the biennium beginning July 1, 2013, the base year is the fiscal period ending June 30, 2014) by the annual change in the DRI Index, or its successor index, as measured in the previous 4th quarter.

(c) For each facility, its allowable costs per Medicaid day is determined using the allowable costs as inflated and resident days, excluding pediatric days as reported in the statement.

(d) The facilities are ranked from highest to lowest by the facility's allowable costs, per Medicaid day.

(e) The basic rate is determined by ranking the allowable costs per Medicaid day by facility and identifying the allowable cost per day at the applicable percentage. If there is no allowable cost per day at the applicable percentage, the basic rate is determined by interpolating the difference between the allowable costs per day that are just above and just below the applicable percentage to arrive at a basic rate at the applicable percentage. The applicable percentage for the period beginning July 1, 2013 is at the 63rd percentile.

(2) The Department provides an augmented rate to nursing facilities who qualify under the Quality and Efficiency Incentive Program as described in OAR 411-070-0437. To receive the augmented rate, the bed capacity must be purchased on or after October 7, 2013 and on or before December 31, 2015. The qualifying nursing facility is paid the augmented rate for each Medicaid-eligible resident.

(3) Nursing facility bed capacity in Oregon shall be reduced by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veteran's Affairs and facilities that either applied to the Oregon Health Authority for a certificate of need between August 1, 2011 and December 1, 2012, or submitted a letter of intent under ORS 442.315(7) between January 15, 2013 and January 31, 2013. An official bed count measurement shall be determined and issued by the Department prior to July 1, 2016 and each quarter thereafter if the goal of reducing the nursing facility bed capacity in Oregon by 1,500 beds is not achieved.

(a) For the period beginning July 1, 2013 and ending June 30, 2016, the Department shall reimburse costs as set forth in section (1) of this rule at the 63rd percentile.

(b) For each three-month period beginning on or after July 1, 2016 and ending June 30, 2020, in which the reduction in bed capacity in licensed facilities is less than the goal described in this section, the Department shall reimburse costs at a rate not lower than the percentile of allowable costs according to the following schedule:

(A) 63rd percentile for a reduction of 1,500 or more beds.

(B) 62nd percentile for a reduction of 1,350 or more beds but less than 1,500 beds.

(C) 61st percentile for a reduction of 1,200 or more beds but less than 1,350 beds.

(D) 60th percentile for a reduction of 1,050 or more beds but less than 1,200 beds.

(E) 59th percentile for a reduction of 900 or more beds but less than 1,050 beds.

(F) 58th percentile for a reduction of 750 or more beds but less than 900 beds.

(G) 57th percentile for a reduction of 600 or more beds but less than 750 beds.

(H) 56th percentile for a reduction of 450 or more beds but less than 600 beds.

(I) 55th percentile for a reduction of 300 or more beds but less than 450 beds.

(J) 54th percentile for a reduction of 150 or more beds but less than 300 beds.

(K) 53rd percentile for a reduction of 1 to 149 beds.

(4) The complex medical add-on rate is 40 percent of the basic rate.

(5) The Department shall add a standard payment to fund implementation of certified nursing assistant staffing requirements contained in OAR 411-086-0100 in accordance with the Legislatively Adopted Budget.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070, OL 2003 chapter 736, OL 2007 chapter 780, OL 2009 chapter 827, OL 2011 chapter 630, & OL 2013 chapter 608