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Oregon Medicaid offers variety of choices for care

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When family members consider getting help for a relative who has become less independent, they may know that financial circumstances make Medicaid the obvious choice. However, they may not know that Medicaid in Oregon offers a variety of care options that promote both independence and dignity. Oregon has a "Medicaid waiver" that allows recipients to choose options ranging from nursing facilities, residential care facilities, assisted living facilities, adult foster care, adult day care, and in-home care. The choices outside of nursing facilities are commonly referred to as "community-based care." While it is empowering to have choices, finding the best care option can be confusing for everyone involved. Each option comes with its own issues.

Nursing facilities

If an elder needs specialized care or skilled nursing, he or she may need to be moved into a nursing facility. Nursing facilities provide the highest level of care for both short-term and long-term Medicaid recipients.

What supplies and services does the Medicaid rate cover in nursing facilities?

The Medicaid rate paid to the facility is intended to be an all-inclusive rate that includes services, supplies, and facility equipment. OAR 411-070-0085(2)(a). Generally, the rate covers all nursing and support services, activities and social services, management of personal incidental funds, special diets, room and board, laundry, basic grooming supplies, haircuts, transportation, and oxygen and oxygen equipment. Depending on the need of the recipient, the nursing facility may receive additional payment for more complex nursing services. OAR 411-070-0027.

However, OAR 411-070-0085(2)(b) also lists services and supplies that are *not* included in the basic Medicaid rate paid to the nursing facility. Remember that Medicaid recipients are also on the Oregon Health Plan (OHP), and many of the services and supplies listed in this portion of the rule are covered by OHP. For example, although the nursing facility does not pay for transportation to and from medical care, OHP does cover medical transportation. Other examples of supplies and services not paid for by the nursing facility but covered by OHP include dental, vision, mental health, and durable medical equipment.

If a service or supply is not covered by the nursing facility as part of the Medicaid rate, a family should ask whether or not it would be covered by OHP. If the resident makes a medically appropriate request and OHP denies authorization, the resident, or his or her representative, should consider an appeal of the decision. The appeal process will vary, depending whether the patient has an OHP "open card" or is in "managed care." An open

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card means that he or she can receive care from any doctor, as long as that doctor is willing to accept OHP. Open cards are also called "fee-for-service." Open card recipients may appeal through the Department of Human Services (DHS), and obtain a hearing before an administrative law judge with the Office of Administrative Hearings. Managed care plans are more common than open cards. A recipient in managed care receives services through plans such as Care Oregon, Tuality, or Providence. If the Medicaid recipient is denied a service by a managed care provider, the notice of denial will describe the appeal process. There is no guarantee that all services not paid for by nursing facility basic Medicaid rate will be covered by OHP, but it is an alternative that an attorney can explore with a client.

What amenities can family members finance?

Although the basic nursing home rate includes a long list of services, family members may want to improve the quality of the patient's life by providing amenities that are not available through Medicaid. There are no administrative rules that specifically address this issue; however, the general rule that the Medicaid rate is an all-inclusive rate still applies.

If the Medicaid recipient has a medical need for a private room, that room must be provided and paid for by the nursing facility. A family's concerns about a shared room often arise out of medical or behavioral problems that are not being adequately addressed by the nursing facility. If that is the case, the family should consider requesting a private room and asking the facility to cover the cost. The nursing facility cannot accept additional private payment to "upgrade" to a private room.

Family members can pay for some amenities not paid for by Medicaid. They can take residents out to dinner, to concerts, and on outings. These types of amenities can go a long way in improving the quality of life for the resident.

What if a nursing facility insists that someone other than the Medicaid recipient sign a guarantee of payment or that the resident pay privately before applying for Medicaid?

These types of arrangements are prohibited. A Medicaid nursing facility must accept Medicaid payment as payment in full. A nursing facility with a Medicaid contract may not require someone other than the resident to sign a guarantee of payment. OAR 411-070-0010(2)(c) states that a facility "must not require, solicit or accept payment, the promise of payment, a period of residence as a private pay resident, or any other consideration as a condition of admission, continued stay, or provision of care or service from the resident, relatives, or any one designated as a 'responsible party.'"

DHS regulates compliance with the rules discussed above and it reserves the right to deny, terminate, or not renew contracts with providers who violate the payment provisions. Patients and their families can report violations directly to their local adult protective services worker. They can also call the Office of Licensing and Quality of Care at 800.232.3020.

Community-based care

If an elder and his or her family would like to explore options other than nursing facilities, there are several community-based choices. Although the services covered by the Medicaid rate are similar to those for nursing facilities, not all the community-based choices provide skilled nursing care. It is important to know the abilities and limits of the care recipient when choosing where to live because some choices require a higher degree of independence than others. Some families may want to consult with a geriatric care manager who specializes in community-based placements.

Residential care facilities

Residential care facilities (RCFs) are an alternative to nursing homes that can offer a greater degree of independence for residents. They provide housing and support services for recipients who do not need twenty-four-hour nursing care. The administrative rules that establish standards of care in RCFs are found in Chapter 11, Division 55 of the Oregon Administrative Rules. Each resident is required to have a screening and a service plan that reflects both the resident's needs and decisions. OAR 411-055-0180.

The specific list of services that the RCF is required to provide is found at OAR 411-055-0210. Generally the RCF should provide room and board, all meals and modified special diets, personal and other laundry services, social and recreational activities, services to assist the resident in performing all activities of daily living twenty-four hours a day, and transportation for medical and social purposes. In addition, the RCF also must provide a wide variety of health services, including medication

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management and disbursement. RCFs are not required to have private bathrooms and kitchenettes, and residents may have to share rooms.

Assisted living facilities

Assisted living facilities (ALFs) are similar to RCFs because they provide housing and supportive services to recipients who do not need round-the-clock nursing care. ALFs can offer more independent living than RCFs because they provide both private bathrooms and small kitchens in the apartment. Many Medicaid recipients living in an ALF also have a private room. Chapter 411, Division 56 of the Oregon Administrative Rules governs the licensing and operation of ALFs. OAR 411-056-0015 sets forth the range of services the ALF must provide under the Medicaid rate. Like RCFs, ALFs provide intermittent nursing services for residents whose medical needs are stable and predictable.

Adult foster homes

Adult foster homes offer a unique care option for a Medicaid recipient. Instead of providing a large facility with many residents, adult foster homes operate in private residences and are limited to a maximum of five residents. Adult foster homes are licensed either by the state or the county, and the regulations governing them are found in Chapter 411, Division 50 of the Oregon Administrative Rules. Division 50 sets forth detailed requirements about services, and health and safety standards. The specific supplies and services that an adult foster home must provide are covered in OAR 411-050-0445. The rule sets forth detailed requirements for bathroom facilities, the size of rooms, and meals. A resident in an adult foster home generally will not have a private kitchen or bathroom.

In-home care

If a Medicaid recipient elects to receive in-home care, DHS will conduct an assessment to determine how many hours of care the recipient requires. The assessment determines the recipient's service priority level (SPL). There are eighteen possible SPLs, but only levels one through thirteen are currently funded by the state. OAR 411-015-0010. The activities of daily living, which are an important part of determining the service priority level, are defined in OAR 411-015-0006. Do not rely on old copies of the rule because it changes frequently. If an applicant is denied based on their SPL, an attorney should review the file and assessment and determine if an administrative hearing is appropriate.

Even if an applicant is at a funded SPL, the number of authorized hours may fall woefully short of meeting the recipient's needs. In situations like this, family members may want to cover the difference by paying for more hours of care. However, family members should be advised that paying for additional Medicaid-related care is not allowed under the Medicaid program for in-home care. OAR 411-030-0050(3)(d) states that the service plan developed by the case manager is considered full payment for services and additional payment to a home care worker for the same services is prohibited.

If the hours paid by DHS are not sufficient to cover the recipient's needs, the care recipient or his or her representative may want to ask for a new assessment, especially if the recipient's needs have changed or worsened. It can be helpful to have a caregiver be involved in the process. If the assessment does not appropriately adjust the hours of care, the family or recipient can file an administrative appeal.

Although family members may not supplement services provided by Medicaid, they can pay for tasks not considered a Medicaid service. For example, a family member could hire someone to come and take the recipient to a concert or play. The family must be careful that they are truly providing supplemental services, and not encroaching on Medicaid's decision about the activities of daily living. If there is a question about what Medicaid covers, the family could review the recipient's assessment or task list.

An important consideration for family members seeking to supplement Medicaid services for in-home care is the "natural supports rule." In Oregon, payment for in-home services is authorized only when resources (natural supports) are not available, not sufficient, or cannot be developed to adequately meet the needs of the individual. OAR 411-030-00401(1). For example, when a family member cares for a Medicaid recipient after work, DHS may reduce the total number of hours of compensated care by the number of hours the family member voluntarily provides care. This is a gray area, because certain applications of the rule may violate federal Medicaid law.

Federal Medicaid law prohibits states from taking into account the financial responsibility of any individual for any applicant or recipient of assistance unless the applicant or recipient is the individual's spouse or the individual's child under age 21. 42 USC §1396(a)(17)(D). State courts have recently invalidated rules that considered live-in caregivers financial resources. *Jensen v. Missouri Department of Health and Senior Services*, 186 SW3d 857(2006); *Gaspar v. The Department of Social and Health Services,* 12 Wn App 42 (2006). If this rule is applied to reduce the number of hours, a careful analysis of DHS's reasons for applying the rule is very important in determining whether or not federal law is at issue. Remember that the Medicaid recipient has forty-five days from the date of notice to request a hearing.

Finding the right fit

When considering what type of care setting is the best for a Medicaid recipient, it is important to understand the person's abilities and medical needs. The good news is that elders who in the past moved directly into nursing facilities now enjoy a greater degree of independence in less-restrictive settings. These opportunities have improved the quality of life for most Medicaid recipients and it is hoped the trend to increase independent choices will continue. ■