

DEPARTMENT OF HUMAN SERVICES  
AGING AND PEOPLE WITH DISABILITIES  
OREGON ADMINISTRATIVE RULES

CHAPTER 411  
DIVISION 30

IN-HOME SERVICES

**411-030-0020 Definitions**

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 030:

~~(1) "AAA" means "Area Agency on Aging" as defined in this rule.~~

(21) "Activities of Daily Living (ADL)" mean those personal, functional activities required by an individual for continued well-being, which are essential for health and safety. Activities include eating, dressing and grooming, bathing and personal hygiene, mobility, elimination, and cognition as defined in OAR 411-015-0006.

~~(3) "ADL" means "activities of daily living" as defined in this rule.~~

~~(42) "APD" "Aging and People with Disabilities "(APD)" means the Aging and People with Disabilities refers to the program within the Department of Human Services primarily responsible for serving seniors and people with disabilities.~~

**Commented [RMG1]:** Updated per RAC suggestion and APD agreement.

(3) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet a specific service need of an eligible individual.

(54) "Area Agency on Aging (AAA)" means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to individuals in a planning and service area. 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.

(56) "Assessment" or "Reassessment" means an assessment as defined in OAR 411-015-0008.

(67) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living. Assistive devices include the use of service animals, general household items, or furniture to assist the individual.

~~(7) "Benefit Plan" means the specific authorization, for in-home, ICP, or spousal pay services with set start and end dates for in-home consumer individuals. The Benefit Plan allows the services to be approved for the consumer. The Benefit Plan authorization is developed with, and approved by, the individual. The Benefit Plan is part of the Client Assessment and Service Planning System.~~

Commented [RMG2]: Updated per RAC suggestion and APD acceptance.

Commented [RMG3]: Housekeeping correction

(8) "Business Days" means Monday through Friday and excludes Saturdays, Sundays, and state or federal holidays.

~~(109) "CA/PS" means the "Client Assessment and Planning System" as defined in this rule.~~

(949) "Case Manager (CM)" means an employee of the Department or Area Agency on Aging who assesses the service needs of an individual applying for services, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements an individual's service plan and monitors the services delivered as described in OAR chapter 411, division 028. For the purposes of this rule, CM may also include Diversion/Transition Coordinators.

~~(110)~~ "Central Office (CO)" means the unit within the Department responsible for program and policy development and oversight.

~~(121)~~ "Client Assessment and Planning System (CA/PS)":

(a) Is a single ~~entry~~ data system used for:

(A) Completing a comprehensive and holistic assessment;

(B) Surveying an individual's physical, mental, and social functioning; and

(C) Identifying risk factors, individual choices and preferences, and the status of service needs.

(b) The CA/PS documents the level of need and calculates an individual's service priority level in accordance with the rules in OAR chapter 411, division 015, calculates the service payment rates, and accommodates individual participation in service planning.

(1312) "~~Consumer~~" or "Consumer-Employer" means an individual eligible for in-home services receiving services through the Consumer-Employer Provider Program.

Commented [RMG4]: Housekeeping Change

(1413) "Consumer-Employed Provider Program" refers to the program described in OAR chapter 411, division 031 wherein a provider is directly employed by a ~~consumer~~individual or their representative to provide hourly in-home services.

(1514) "Contingency Fund" means a monetary amount that continues month to month, if approved by a case manager, that is set aside in the Independent Choices Program service budget to purchase identified items that substitute for personal assistance.

(1615) "Contracted In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR chapter 333, division 536 that provides hourly contracted in-home services to individuals receiving services through the Department or Area Agency on Aging.

(1716) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices consist of all available services under the Medicaid home and community-based service options, the utilization of assistive devices, natural supports, architectural modifications, and alternative service resources (defined in OAR 411-015-0005). Less costly alternatives may include resources not paid for by the Department.

~~(1817)~~ "Debilitating Medical Condition" means the individual's condition is severe, persistent, and interferes with the individual's ability to function and participate in most activities of daily living.

~~(1918)~~ "Department" means the Department of Human Services (DHS), APD.

~~(2019)~~ "Discretionary Fund" means a monetary amount set aside in the Independent Choices Program service budget to purchase items not otherwise delineated in the monthly service budget or agreed to be savings for items not traditionally covered under Medicaid home and community-based services. Discretionary funds are expended as described in OAR 411-030-0100.

~~(2420)~~ "Disenrollment" means either voluntary or involuntary termination of a participant from the Independent Choices Program.

~~(2221)~~ "Employee Provider" means a worker who provides services to, and is a paid provider for, a participant in the Independent Choices Program.

~~(2322)~~ "Employment Relationship" means the relationship of employee and employer involving an employee provider and a participant.

~~(2423)~~ "Exception" means the following:

(a) An approval for payment of a service plan granted to a specific individual in their current residence or in the proposed residence identified in the exception request that exceeds the CA/PS assessed service payment levels for individuals residing in community-based care facilities or the maximum hours of service as described in OAR 411-030-007071 for individuals residing in their own homes or the home of a relative.

(b) An approval for shift care service plan granted to a specific individual that does not otherwise meet the criteria as described in OAR 411-030-0068 based upon the service needs of the individual as determined by the Department.

(c) An approval of a service plan granted to a specific individual and a homecare worker to exceed the limitations as described in OAR 411-

030-0070(5) based upon the service needs of the individual as described in OAR 411-030-0072 determined by the Department.

Commented [RMG5]: Housekeeping change.

~~(d) "Exceptional rate" or "exceptional payment." The approval of an exception is based on the service needs of the individual and is contingent upon the individual's service plan meeting the requirements in OAR 411-027-0020, OAR 411-027-0025, and OAR 411-027-0050, and 411-030-0071.~~

~~(de) Additional hours provided to A request from an individuals who meets the criteria for shift services, as described in OAR 411-030-0068, that exceed the 16 hours of service per day.~~

(245) "FICA" is the acronym for the Social Security payroll taxes collected under authority of the Federal Insurance Contributions Act.

(256) "Financial Accountability" refers to guidance and oversight which act as fiscal safeguards to identify budget problems on a timely basis and allow corrective action to be taken to protect the health and welfare of individuals.

(267) "FUTA" is the acronym for Federal Unemployment Tax Assessment which is a United States payroll (or employment) tax imposed by the federal government on both employees and employers.

(278) "Homecare Worker (HCW)" means a provider, as described in OAR 411-031-0040, directly employed by a consumer individual to provide hourly in-home services to the eligible consumer individual.

(a) The term homecare worker includes:

(A) A consumer individual-employed provider in the Spousal Pay and Oregon Project Independence Programs;

(B) A consumer individual-employed provider that provides state plan personal care services to individuals; and

(C) A relative providing Medicaid in-home services to an individual living in the relative's home.

(b) The term homecare worker does not include an Independent Choices Program provider or a personal support worker enrolled

through Developmental Disability Services or the Addictions and Mental Health Division.

(~~2829~~) "Hourly Services" mean the in-home services, including activities of daily living and instrumental activities of daily living, that are provided at regularly scheduled times.

(~~2930~~) "Household" means a group of individuals that live together within the same dwelling. For homeless individuals, the household consists of the individuals who consider themselves living together.

~~(321) "IADL" means "instrumental activities of daily living" as defined in this rule.~~

~~(332) "ICP" means "Independent Choices Program" as defined in this rule.~~

(~~3033~~) "ICP Participant Agreement" means the form the ~~consumer~~individual signs indicating that they understand their roles and responsibilities in the ICP program.

(~~3135~~) "Independent Choices Program (ICP)" means a self-directed in-home services program in which a participant receives a cash benefit to purchase goods and services identified in the participant's service plan and prior approved by the Department or Area Agency on Aging.

(~~32~~) "Individual" means a person age 65 or older, or an adult with a physical disability, applying for or eligible for services per OAR 411-015-0100.

(~~33~~) "Individualized Back-Up Plan" means a plan incorporated into an Independent Choices Program service plan to address critical contingencies or incidents that pose a risk or harm to a participant's health and welfare.

(~~347~~) "In-Home Services" mean ~~the activities of daily living and instrumental activities of daily living that assist an individual to stay in their own home or the home of a relative~~those services that meet an individual's assessed need related to activities of daily living and instrumental activities of daily living- when residing in a living arrangement that meets the criteria

~~described in OAR 411-030-0033 while the individual is living in their own home or in the home of a relative.~~

**Commented [RMG6]:** Updated per RAC discussion and APD agreement.

(358) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in IADL are identified in OAR 411-015-0007.

(3639) "Liability" refers to the dollar amount an individual with excess income contributes to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(3740) "Medicaid OHP Plus Benefit Package" means only the Medicaid benefit packages provided under OAR 410-120-1210(4)(a) and (b). This excludes individuals receiving Title XXI benefits.

(3844) "Natural Supports" or "Natural Support System" means resources and supports (e.g. relatives, friends, neighbors, significant others, roommates, or the community) who are willing to voluntarily provide services to an individual without the expectation of compensation. Natural supports are identified in collaboration with the individual and the potential "natural support". The natural support is required to have the skills, knowledge, and ability to provide the needed services and supports.

(3942) "Oregon Project Independence (OPI)" means the program of in-home services described in OAR chapter 411, division 032.

(403) "Participant" means an individual eligible for the Independent Choices Program.

(414) "Person-Centered Service Plan" ~~is~~ **(Service Plan)** means, for Medicaid eligible individuals, the written details of the supports, desired outcomes, activities, and resources required for an individual to achieve and maintain personal goals, health, and safety. The plan is written by the case manager ~~with input and review~~ **approval from the individual.**

**Commented [RMG7]:** Housekeeping change

**Commented [RMG8]:** Written comment received and approved by APD

~~(42) "Preventative" means services and supports that do not meet the definition of the ADLs defined in OAR 411-015-0060 and IADLs defined in OAR 411-015-0070 including the tasks and assistances types defined in those rules.~~

**Commented [RMG9]:** This term was only referenced in the exception rules. Since the term is being edited out, the definition is no longer needed.

(425) "Provider" means the person who renders the services.

(436) "Rate Schedule" means the rate schedule in OAR 411-027-0170 and maintained by the Department at <http://www.dhs.state.or.us/spd/tools/program/osip/rateschedule.pdf>.

(447) "Relative" means a person, excluding an individual's spouse, who is related to the individual by blood, marriage, or adoption.

(458) "Representative" is a person either appointed by an individual to participate in service planning or managing the duties of a consumer-employer on the individual's behalf or an individual's natural support with longstanding involvement in assuring the individual's health, safety, and welfare. There are additional responsibilities for an ICP representative as described in OAR 411-030-0100. An ICP representative is not a paid employee provider regardless of relationship to a participant.

Commented [RMG10]: Housekeeping change

(4649) "Service Budget" means a participant's plan for the distribution of authorized funds that are under the control and direction of the participant within the Independent Choices Program. A service budget is a required component of the participant's service plan.

(4759) "Service Need" means the assistance an individual requires from another person for those functions or activities identified in OAR 411-015-0006 and ~~OAR~~ 411-015-0007.

(4854) "Service Period" means two consecutive workweeks for a total of 14 days.

(4952) "Shift Services" are hourly services provided by awake homecare workers, Independent Choices Program employee providers, or a contracted in-home care agency provider to an individual who is authorized to receive a minimum of 16 hours of services during a 24-hour work period. ~~Individuals that have ventilator dependency and have quadriplegia or similar conditions and utilize 24 hours of awake hourly services may have homecare workers paid above the rate schedule.~~

Commented [RMG11]: Removed per RAC suggestion and APD agreement.

(503) "Spouse" means a person that is legally married to an individual as defined in OAR 461-001-0000.

(514) "SUTA" is the acronym for State Unemployment Tax Assessment. State unemployment taxes are paid by employers to finance the unemployment benefit system that exists in each state.

(525) "Tasks" means distinct parts of an activity of daily living.

(536) "These Rules" mean the rules in OAR chapter 411, division 030.

(547) "Workweek" is defined as 12:00 a.m. on Sunday through 11:59 p.m. on Saturday.

Stat. Auth.: ORS 409.050, 410.070, 410.090

Stats. Implemented: ORS 410.010, 410.020, 410.070

#### **411-030-0040 Eligibility Criteria**

(1) In-home services are provided to individuals who meet the established priorities for service as described in OAR chapter 411, division 015 who have been assessed to be in need of in-home services. ~~(a)~~ Payments for in-home services are not intended to replace the resources available to an individual from the individual's natural supports.

~~(b) An individual whose service needs are sufficiently and appropriately met by available natural supports is not eligible for in-home services.~~

(2) An individual receiving Medicaid in-home services must:

(a) Meet the established priorities for service as described in OAR chapter 411, division 015.

(b) Meet all the eligibility requirements in OAR 411-015-0010 through 411-015-0100.

(c) Reside in a living arrangement described in OAR 411-030-0033.

(3) An individual receiving services through the Independent Choices Program must:

(a) Meet the established priorities for service as described in [OAR chapter 411, division 015](#);

(b) Be a current recipient of OSIPM (Oregon Supplemental Income Program Medical);

(c) Reside in a living arrangement described in [OAR 411-030-0033](#); and

(d) Be 18 years of age or older.

~~(4) To be eligible for Medicaid in-home services, an individual must employ an enrolled homecare worker or contracted in-home care agency. To be eligible for the ICP, a participant must employ an employee provider.~~

~~(5) Initial eligibility for Medicaid in-home services, or the ICP, does not begin until an individual's service plan has been authorized by the Department or the Department's designee. The service plan must identify the provider who delivers the authorized services, include the date when the provision of services begins, and include the maximum number of hours authorized. Service plans must be based upon the least costly means of providing adequate services.~~

~~(6) If, for any reason, the employment relationship between an individual and provider is discontinued, an enrolled homecare worker or contracted in-home care agency must be employed within 14 business days for the individual to remain eligible for in-home services. A participant of the ICP must employ an employee provider within 14 business days to remain eligible for ICP services. The individual's case manager has the authority to waive the 14 business day restriction if the individual is making progress towards employing a provider.~~

~~(7) An eligible individual who has been receiving in-home services who temporarily enters a nursing facility or medical institution must employ an enrolled homecare worker or contracted in-home care agency within 14 business days of discharge from the facility or institution for the individual to remain eligible for in-home services. A participant of the ICP must employ an employee provider within 14 business days of discharge to remain eligible for ICP services.~~

(84) ~~CONSUMER-~~EMPLOYER RESPONSIBILITIES.

Commented [RMG12]: Housekeeping change

(a) ~~In order to~~ To be eligible for in-home services provided by a homecare worker, an individual must be able to, or designate a representative to:

- (A) Locate, screen, and hire a qualified homecare worker;
- (B) Supervise and train the homecare worker;
- (C) Schedule the homecare worker's work, leave, and coverage;
- (D) Track the hours worked and verify the authorized hours completed by the homecare worker;
- (E) Recognize, discuss, and attempt to correct any performance deficiencies with the homecare worker;
- (F) Discharge an unsatisfactory homecare worker; and
- (G) Follow all employer responsibilities required by law to ensure the workplace is safe from harassment.

(b) The Department may require individuals who have failed to meet the responsibilities in subsection (a) of this section to designate a representative to exercise these responsibilities. A representative of an individual may not be a homecare worker providing homecare worker services to the individual.

(A) Individuals who have failed to meet the responsibilities in subsection (a) of this section and who does not have a representative are ineligible for in-home services provided by a homecare worker.

(B) Individuals must also be offered other available community-based service options to meet the individual's service needs, including contracted in-home care agency services, nursing facility services, or other community-based service options.

(c) An individual determined ineligible for in-home services provided by a homecare worker and who does not have a representative may request in-home services provided by a homecare worker at the individual's next re-assessment, but no sooner than 12 months from the date the individual was determined ineligible.

(A) To reestablish eligibility for in-home services provided by a homecare worker, an individual must attend training and acquire, or otherwise demonstrate, the ability to meet the employer responsibilities in subsection (a) of this section. Improvements in health and cognitive functioning, for example, may be factors in demonstrating the individual's ability to meet the employer responsibilities in subsection (a) of this section.

(B) If the Department determines an individual may not meet the individual's employer responsibilities, the Department may require the individual appoint an acceptable representative.

(d) The Department retains the right to approve the representative selected by an individual. Approval may be based on, but is not limited to, the representative's criminal history, protective services history, or credible allegations of fraud or collusion in fraudulent activities involving a public assistance program.

(e) If an individual's designated representative is unable to meet the employer responsibilities of subsection (a) of this section, or the Department does not approve the representative, the individual must designate a different representative or select other available services.

(f) An individual with a history of credible allegations of fraud or collusion in fraud with respect to in-home services is not eligible for in-home services provided by a homecare worker.

(95) REPRESENTATIVE.

(a) The Department may require that an individual obtain a representative to act as the consumer-employer or for service planning purposes.

**Commented [RMG13]:** Clarify there are two types of representatives discussed in this rule.

(b) The Department, or the Department's designee, may deny an individual's request for any representative if the representative has a history of a substantiated adult protective service complaint as described in OAR chapter 411, division 020. The individual may select another representative.

(c) An individual with a guardian must have a representative for to act as the consumer-employer and for service planning purposes. A guardian may designate themselves as the representative.

**Commented [RMG14]:** Clarify intent, housekeeping change

(d) A representative may not be a paid caregiver for the individual they are representing.

**Commented [RMG15]:** Clarify intent, housekeeping change

~~(406)~~ Additional eligibility criteria for Medicaid in-home services exist for individuals eligible for:

(a) The Consumer-Employed Provider Program as described in OAR chapter 411, division 031;

(b) The Independent Choices Program as described in OAR 411-030-0100 of these rules; and

(c) The Spousal Pay Program as described in OAR 411-030-0080 of these rules.

~~(417)~~ Individuals living in any of the following settings are not eligible for in-home services:

(a) A licensed community-based care facility, including an adult foster home;

(b) A nursing facility;

(c) Prison;

(d) A hospital; or

(e) Any other institutions or facility that provide assistance with ADLs or other services.

Commented [RMG16]: Clarify intent.

(128) Individuals with excess income must contribute to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

Stat. Auth.: ORS 409.050, 410.070, 410.090

Stats. Implemented: ORS 410.010, 410.020, 410.070

#### 411-030-0070 Maximum Hours of Service

##### (1) LEVELS OF ASSISTANCE FOR DETERMINING SERVICE PLAN HOURS.

(a) "Minimal Assistance" means an individual is able to perform the majority of an activity, but requires some assistance from another person.

(b) "Substantial Assistance" means an individual is able to perform only a small portion of the tasks that comprise an activity without assistance from another person.

(c) "Full Assistance" means an individual needs assistance from another person through all tasks of an activity every time the activity is attempted.

##### (2) MAXIMUM SERVICE PERIOD HOURS FOR ADL.

(a) The planning process uses the following maximum hours limitations for ~~each service period authorization time allotments~~ for ADL tasks. Maximum hours in each assistance level are not guaranteed. Hours authorized must be based on the service needs of an individual as determined by the Case Manager during the person-centered service planning process.

Commented [RMG17]: Updated per RAC suggestion and APD agreement.

(b) For in-home benefit plans created after May 21, 2018, the following maximums apply:

(A) Eating:

(i) Minimal assistance, three hours.

(ii) Substantial assistance, nine hours.

(iii) Full assistance, fourteen hours.

(B) Dressing and Grooming:

(i) Minimal assistance, two hours.

(ii) Substantial assistance, seven hours.

(iii) Full assistance, nine hours.

(C) Bathing and Personal Hygiene:

(i) Minimal assistance, five hours.

(ii) Substantial assistance, seven hours.

(iii) Full assistance, twelve hours.

(D) Mobility:

(i) Minimal assistance, five hours.

(ii) Substantial assistance, seven hours.

(iii) Full assistance, twelve hours.

(E) Elimination (Toileting, Bowel, and Bladder):

(i) Minimal assistance, five hours.

(ii) Substantial assistance, nine hours.

(iii) Full assistance, fourteen hours.

(F) Cognition:

(i) Minimal assistance, three hours.

(ii) Substantial assistance, six hours.

(iii) Full assistance, twelve hours.

(bc) Service plan hours for ADL may only be authorized for an individual if the individual requires assistance (minimal, substantial, or full assist) from another person in the tasks associated with the activity of daily living as determined by a service assessment applying the parameters in OAR 411-015-0006.

(ed) The Case Manager may authorize fewer hours than the maximum number of hours in any or all ADL tasks based on their assessment of the individual's unmet need. The Case Manager must document the reason for authorizing fewer hours than the maximum number of hours allowed. The case manager may authorize fewer hours than the maximum ~~for for one any of the following~~ defined reasons, ~~including, but not limited to:~~

(A) Reduced frequency or duration of an ADL need.

(B) Durable medical equipment or home modification reduces need for assistance.

(C) Individual preference.

(D) Natural supports.

(E) Provided or funded by another agency.

(ee) For households with two or more eligible individuals, each individual's ADL service needs must be considered separately.

(ef) Hours authorized for ADL are paid at the rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for ADLs paid at the rates in

Commented [RMG18]: Updated per RAC and APD agreement

Commented [RMG19]: Updated per RAC and APD agreement

accordance with the rate schedule. Participants of the Independent Choices Program may determine their own employee provider pay rates, but must follow all applicable wage and hour rules and regulations.

(3) MAXIMUM SERVICE PERIOD HOURS FOR IADL.

(a) The planning process uses the following limitations for time allotments for IADL tasks. Maximum hours in each assistance level are not guaranteed. Hours authorized must be based on the unmet service needs of an individual as determined by the case manager during the person-centered service planning process.

(A) Medication Management:

- (i) Minimal assistance, one hour.
- (ii) Substantial assistance, two hours.
- (iii) Full assistance, five hours.

(B) Transportation:

- (i) Minimal assistance, one hour.
- (ii) Substantial assistance, one hour.
- (iii) Full assistance, two hours.

(C) Meal Preparation:

- (i) Minimal assistance:
  - (I) Breakfast, one hour.
  - (II) Lunch, one hour.
  - (III) Supper, two hours.
- (ii) Substantial assistance:

(I) Breakfast, two hours.

(II) Lunch, two hours.

(III) Supper, three hours.

(iii) Full assistance:

(I) Breakfast, five hours.

(II) Lunch, five hours.

(III) Supper, six hours.

(D) Shopping:

(i) Minimal assistance, one hour.

(ii) Substantial assistance, two hours.

(iii) Full assistance, three hours.

(E) Housekeeping and Laundry:

(i) Minimal assistance, two hours.

(ii) Substantial assistance, five hours.

(iii) Full assistance, nine hours.

(b) Hours authorized for IADL are paid at the rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for IADLs paid at the rates in accordance with the rate schedule. Participants of the Independent Choices Program may determine their own employee provider pay rates, but must follow all applicable wage and hour rules and regulations.

(c) When two or more individuals eligible for IADL task hours live in the same household, the assessed need in medication management and transportation must be authorized separately. Payment is made for the individual with the highest of the allotments in meal preparation, shopping, and housekeeping and laundry and a total of two additional IADL hours per service period for each additional individual to allow for the specific IADL needs of the other individuals.

(d) Service plan hours for IADL tasks may only be authorized for an individual if the individual requires assistance (minimal, substantial, or full assist) from another person in that IADL task as determined by a service assessment applying the parameters in OAR 411-015-0007. Hours authorized must incorporate the frequency and the duration of the tasks within each instrumental activity of daily living. For housekeeping, the size of the home may be used to reduce the hours. For meal preparation, hours must be reduced if an individual is receiving Medicaid home delivered meals.

(e) The Case Manager may authorize fewer hours than the maximum number hours in any or all IADLs based on their assessment of the individual's unmet need. The Case Manager must document the reason for authorizing fewer hours than the maximum hours. The Case Manager may reduce hours for any one of the following a defined reasons, including, but not limited to:

- (A) Reduced frequency or duration of an IADL need.
- (B) Durable medical equipment or home modification reduces need for assistance.
- (C) Individual preference.
- (D) Natural supports.
- (E) Provided by or funded by another agency.
- (F) Small living space.

(4) When one or more eligible individuals are living in the same household ~~is eligible for~~ and receiving in-home services, the ~~amount~~ total number of

**Commented [RMG20]:** Updated per RAC suggestion and APD agreement.

**Commented [RMG21]:** Updated per RAC suggestion and APD agreement

**Commented [RMG22]:** Updated per RAC suggestion and APD agreement

hours authorized for ADLs and IADLs may not exceed 24 hours within any 24-hour period in the same household unless an exception is granted as described in OAR 411-030-0071.

**Commented [RMG23]:** Added statement to clarify that an exception may be granted to go over this limit.

(5) For the creation of a new service plan (resulting from an assessment) beginning September 1, 2016, and for all service plans beginning July 1, 2017, subsection (a) and either subsection (b) or (c) of this rule will apply to a homecare worker:

(a) Hourly or shift services provided are limited to 16 hours of awake care during a 24-hour work period.

(b) Hourly services provided may not exceed 50 hours per workweek if the homecare worker's average paid workweek hours in the months of March, April, and May 2016 equals or exceeds 40 hours per workweek.

(c) Hourly services provided may not exceed 40 hours per workweek if the homecare worker's average paid workweek hours in the months of March, April, and May 2016 is less than 40 hours per workweek or if the homecare worker became an enrolled provider after May 2016. Under this subsection, homecare workers that provide hourly services within the same workweek may not exceed 40 hours per workweek.

(6) In an emergency or unanticipated situation where the homecare worker must provide critical care to ensure the health or safety of the individual and the Department is unavailable to provide prior-authorization, the following shall be permitted if the homecare worker or individual notifies the Department within two business days:

(a) Additional hours worked to meet an ADL need A homecare worker may be authorized to provide services totaling more than the hours established by section (5)(b) and (c) of this rule.- if they are prior authorized by the Department. In emergency situations, when the Department is not available, a homecare worker may work additional life-sustaining hours, but must notify the Department within two business days.

~~(b) Additional hours worked to meet an ADL need that exceed the total amount authorized by the Department on the service plan authorization.~~

~~(c) Additional hours homecare worker may be authorized by the Department to work more than totaling more than the hours established by section (5)(a) of this rule 16 hours of hourly services during a 24-hour workperiod if an unanticipated need arises that requires the homecare worker to remain awake to provide necessary ADL care.~~

**Commented [RMG24]:** Per RAC suggestion, this section has been restructured to clearly indicate when the homecare worker may exceed their hours in an emergency or unanticipated situation.

~~(67)~~ A provider may not receive payment from the Department for more than the total amount authorized by the Department on the service plan authorization form under any circumstances. All service payments must be prior-authorized by a case manager. This section shall may be waived if the criteria in (6) are met.

**Commented [RMG25]:** Per RAC suggestion and APD agreement

~~(78)~~ Case managers must assess and utilize as appropriate, natural supports, cost-effective assistive devices, durable medical equipment, housing accommodations, and alternative service resources (as defined in OAR 411-015-0005) that may reduce the need for paid assistance.

~~(89)~~ The Department may authorize paid in-home services only to the extent necessary to supplement potential or existing resources within an individual's natural supports system.

~~(910)~~ Payment by the Department for Medicaid home and community-based services are only made for the tasks described in this rule as ADL or IADL tasks. Services must be authorized to meet the needs of an eligible individual and may not be provided to benefit an entire household.

#### ~~(10) EXCEPTIONS TO MAXIMUM HOURS OF SERVICE.~~

~~(a) To meet an extraordinary ADL service need, as identified in the assessment and verified by the Department, the hours authorized for ADL may exceed the full assistance hours (described in section (2) of this rule) as long as the total number of ADL hours in the service plan does not exceed 62 hours per service period.~~

~~(b) Service period plans that exceed 62 ADL hours may only be approved by Central Office when the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050 is met.~~

~~(c) As long as the total number of IADL task hours in the service plan does not exceed 35 hours per service period and the service need, as assessed and verified by the Department, the hours authorized for IADL tasks may exceed the hours for full assistance (as described in section (3) of this rule) for the following tasks and circumstances:~~

~~(A) Housekeeping based on medical need (such as immune deficiency).~~

~~(B) Extraordinary IADL needs in medication management or service-related transportation.~~

~~(d) Service period plans that exceed 35 hours in IADL tasks may only be approved by Central Office when an individual meets the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050.~~

(124) An individual who meets the Extended Waiver Eligibility criteria outlined in OAR 411-015-0030 is eligible to receive a maximum total of 10 hours per service period to accomplish ADLs and IADLs.

Stat. Auth.: ORS 409.050, 410.070, 410.090

Stats. Implemented: ORS 410.010, 410.020, 410.070

#### **411-030-0071 EXCEPTIONS TO MAXIMUM HOURS OF SERVICE**

##### **(1) Eligibility for In-Home Exceptions to Maximum Hours of Service.**

~~(a) If the Department determines the consumer's individual's assessed service needs will not be met within the maximum numbers of hours for a specific ADL or specific IADL set forth in OAR 411-030-0070, and the consumer individual meets the requirements in this rule, the consumer individual shall receive an exception to the maximum hours per ADL and IADL.~~

**Commented [RMG26]:** Per RAC suggestion and APD agreement.

**Commented [RMG27]:** Housekeeping change

**Commented [RMG28]:** Housekeeping change

(b) If the Department determines the individual's assessed service needs will not be met within the maximum number of hours to address cognitive impairments, and the individual meets the requirements in this rule, the individual shall receive an exception to the maximum hours in Cognition and other effected ADLs defined in OAR 411-015-0006.

**Commented [RMG29]:** Updated per RAC suggestion and APD agreement.

(c) The Department may deny an exception if the request is:

(A) Based solely on a desire for services outside of assessed service needs.

(B) Not medically appropriate.

(C) For assistance types not allowed by rule OAR 411-015-0006 and OAR 411-015-0007 for a particular ADL or IADL.

**Commented [RMG30]:** Added per RAC suggestion and APD agreement

(D) For services not covered in the 1915(k) State Plan, OAR 411-015-0006, or OAR 411-015-0007.

(E) For tasks not identified in OAR 411-015-0006 and OAR 411-015-0007 preventative services.

**Commented [RMG31]:** Updated to redefine intent per RAC suggestion and APD agreement.

(2) Responsibility for Applying for an In-home Exception.

(a) A consumer individual, or their representative, may make an initial exception request either orally or in writing if the consumer individual believes their service plan is not meeting, or will not meet, their service needs.

(b) If the consumer individual, or their representative, requests an exception or expresses concerns that their service needs are not being met, the case manager must help the consumer individual apply for an exception, including completing required forms and gathering Department-required documentation.

(c) If the consumer individual's case manager assesses, or is notified by others with knowledge of the consumer individual's needs, that the consumer individual's needs exceed the maximum hours, the case manager must work with the consumer individual to determine the appropriate number of hours and submit an exception application;

(d) If the number of hours the case manager approves or recommends is fewer than the number requested by the consumer individual or their representative, the consumer individual's requested exception shall be reviewed as presented by the consumer individual, and a decision will be made on that request per the process defined in section (3) of this rule.

(e) In-home care providers may not submit requests for exceptions. They may notify the case manager of concerns and the case manager shall discuss the concerns with the consumer individual or their representative and ask if the consumer individual wants to apply for an exception.

### (3) Exception Application Process.

(a) A consumer individual may apply for an exception, described in section (2) of this rule, either by completing:

(A) -an exception application form, available from the case manager, and providing any information that supports the request for additional hours; or

(B) by requesting that their case manager complete the exception application form on their behalf.

(b) Prior to processing an application for an exception, the case manager must discuss alternate ways, if any, to meet the consumer individual's needs consistent with the consumer individual's right to independence and choice.

(c) After discussing alternatives ways to meet the consumer individual's needs described in subsection (b) of this rule, if

**Commented [RMG32]:** Updated per RAC suggestion and APD agreement.

the consumer individual continues to desire an exception, then the exception application shall be processed.

(d) The Exception Application Form, regardless of who completes the form, must be signed by the consumer individual or their representative in order for the application to be reviewed.

(e) The CA/PS assessment must have been completed within three months before the exception request, and it must represent the consumer individual's current condition and functioning. If the consumer individual's application for an exception is not within the timeframe noted in this subsection, a new assessment must be completed to document current needs. DHS CO may waive this requirement in special circumstances which must be documented in the consumer individual's file.

(f) If the wait for a new assessment threatens the health, safety, or welfare of the consumer individual, as determined by the Department, the Department shall waive the three-month requirement in subsection (d) of this rule.

(g) The Exception Application Form must clearly describe:

(A) The frequency of the task that is needed, based on the number of times per day or week that assistance is needed.

(B) The duration of the task, based on the average amount of time a task takes each time the task is attempted.

(C) Service needs that occur on a regular but unpredictable schedule.

(D) The number of providers needed for each task and an explanation of why, if applicable, the tasks take more than one provider.

(E) The reasons why the current hours do not meet the needs of the consumer individual.

(F) Any other information that explains the need for the exception.

(h) The Exception Application Form shall include an attestation that all the information is accurate and truthful.

(i) The ~~consumer~~ individual, or their representative, is responsible for ensuring that sufficient documentation is provided. A case manager ~~may shall~~ assist the ~~consumer~~ individual in collecting the requested documentation. If the requested documentation is not provided to the Department, DHS may issue an exception denial.

**Commented [RMG33]:** Updated per RAC suggestion and APD agreement

(4) Required Documentation.

(a) All Exception applications must include the Exception Application Form. The form must be complete and accurate.

(b) To support the application, the Department may require the ~~consumer~~ individual, or their representative, to provide further documentation during the Exception decision making process. This documentation, in addition to the Exception Application Form, may include, but is not limited to:

(A) An Exception Calculator, which will be provided by the Department, upon request;

(B) Care provider time logs detailing the support needs of the individual throughout the day; and

(C) Relevant medical and mental health records to support the specific exception request.

(5) Exception Decision Making Authority.

(a) Local office management shall make final decisions on the exception application if the exception application does not exceed the total maximum hours, defined in OAR 411-030-0070:

(A) The ADL limit is 73 hours per service period; ~~and or~~

**Commented [RMG34]:** APD's intent is that if either hours are above the limit, CO will need to approve.

(B) The IADL limit is 35 hours per service period.

(b) Only DHS CO shall make final decisions on exceptions exceeding the maximum hour limits defined in (5)(a)(A) and (B) of this section.

(c) If the exception application meets the criteria defined in (5)(a) of this section, the local office manager must review the exception application, related documents, and the CA/PS assessment comments for accuracy, completeness, and justification of the request and either approve, partially approve, or deny the request in writing no more than 14 days from the date of the exception request. The consumer individual, or their representative, may appeal any unfavorable decision.

(d) If the exception application exceeds the authority defined in (5)(ba) of this section, the local office management must submit the exception application to DHS CO within three (3) business days of receipt of the application.

**Commented [RMG35]:** Per RAC suggestion and APD agreement.

(e) Unless (5)(f) or 5(g) of this rule applies, DHS CO has no more than 30 days from the date of receipt of the exception application and any supporting documentation has been received by the individual to complete its review and make a determination.

**Commented [RMG36]:** Updated per RAC suggestion to clarify intent and APD agreement.

(f) In emergency situations that threaten the health, welfare or safety of the individual, DHS CO will make a decision within two (2) business days of receipt of the application. DHS CO may elect to make a decision without all of the required documentation, however any approvals will only be made for no more than the end of proceeding service next service period.

**Commented [RMG37]:** CO has identified a scenario where a quick approval is needed, however there is not enough time to gather all of the appropriate documentation.

(g) If DHS CO determines that it needs additional information, it will notify the case manager or local office manager in writing within three (3) business days of receipt of the application. The case manager, or local office manager must notify the consumer individual, or their representative, within two business days that additional information is needed.

(h) The consumer individual, or their representative, or case manager must provide the requested information to DHS CO within 14 days of

the Department's request. The request for additional information will specify the due date and explain how to submit the required information.

(A) DHS CO has 14 days from the date of receipt of the additional information to make a determination.

(B) If the consumerindividual fails to timely provide the requested information, DHS CO will complete the review based on the documentation in its possession. DHS CO has 14 days from the date of the consumerindividual's deadline for additional information to complete the review.

(C) If the consumerindividual, or their representative, responds to the request for additional information after the exception application has been denied due to a failure to provide additional information, the consumerindividual's response will be considered a new request for an exception, with a new effective date.

(D) If the consumerindividual submits the required documentation after the 14-day timeframe, the consumerindividual may request an extension for good cause and request that the DHS CO issue a revised decision.

(E) The consumerindividual may request a good cause extension prior to the expiration of 14-day timeframe by requesting it via their case manager.

(F) Good cause exists when an action, delay, or failure to act arises from an excusable mistake or from factors beyond a consumerindividual's reasonable control.

(i) For each Exception Application:

(A) If the Department determines that the documentation supports the requested additional hours over the maximum for the specific ADLs or IADLs, the exception will be granted.

(B) If the Department determines that the documentation supports additional hours but not as many hours as requested or for the timeframe requested, the exception will be granted for only those additional hours supported by the documentation.

(C) If DHS determines that the documentation does not support any additional hours over the maximum, the exception application will be denied.

(D) If DHS denies any portion of an Exception Application, as described in (h)(B) and (h)(C) of this subsection, the consumer individual, or their representative, may request a hearing.

#### (6) Exception Application Reviews and Decision Making.

(a) All exception applications must be for services and supports provided by APD. This means that the need must meet the definitions in each ADL or IADL and match the tasks and assistance types defined in those rules.

(b) Exception approvals are effective no earlier than the date the Exception Application is requested by the consumer individual and received by the case manager and the home care provider has been authorized to work. If these do not occur on the same date, whichever is later will be the effective date.

(c) To justify the need for additional hours, the Department will review any documentation available, including:

(A) Assessment Comments to ensure that the assessed need meets OAR definitions;

(B) Treatments that may drive care needs;

(C) Diagnosis that may drive care needs;

(D) Medical documentation that the way services are being provided is appropriate to the needs of the consumer individual;

(E) Medical documentation, including those from the Long-Term Care Community Nurse or Behavior Support Specialists, that shows that the current level of services is not meeting the consumer individual's needs;

(F) The reasons driving increased duration and frequency; and

(G) Other information explaining or related to the need for additional hours.

(d) To determine the appropriate number of exception hours, the Department shall review:

(A) Frequency of the care needs that require additional time in the relevant ADLs and IADLs.

(B) Duration of the care needs that require additional time in the relevant ADLs and IADLs.

(C) The reasons driving the increased duration and frequency.

(D) The number of individuals necessary to perform an assessed task.

(E) The complexity of the consumer individual's care needs.

(F) Whether denying the exception would put the consumer individual at risk of placement out of home if the consumer individual prefers to live in their own home.

(G) Whether or not denying the exception would result in substantial unmet needs of the consumer individual.

(e) The Department may reduce the requested hours if the consumer individual's needs and choices are already met by:

(A) The availability of natural supports as defined in OAR 411-030-0020(38);

(B) Durable Medical Equipment or assistive devices/technology;

(C) Emergency Response Systems;

(D) Home and Environmental Modifications;

(E) Home Delivered Meals;

(F) Other supports that replace the need for human assistance as determined on a case-by-case basis consistent with consumer individual choice;

(G) Requested hours do not meet ADL and IADL definitions; and

(H) The way tasks are being provided are not medically appropriate as determined by:

(i) Information from the consumer individual's medical professionals;

(ii) APD's Long Term Care Community Nurses or other nurses familiar with the care of the consumer individual; or

(iii) Documentation provided from recent hospitalizations or nursing facility stays.

(7) Notification.

(a) The Department shall notify the consumer individual about the outcome of the exception request in the notice of hours authorization decision, or an amended notice, if appropriate.

(b) Notification shall include:

(A) The name of the person who applied for exceptional service hours.

(B) The date the request was approved or denied.

(C) For each ADL and IADL, the number of hours requested, compared to maximum hours and total approved hours.

(D) A reference to the attached 514 Exception Application Form.

(E) A summary of the reasons why the exceptional hours requested were approved or denied.

(F) The duration of the exception.

(G) Information on hearing rights and how to request a hearing.

(8) Duration. An exception is valid for the period defined in the notice, not to exceed one calendar year.

(9) Reassessments.

(a) If an ~~consumer~~ individual has an existing exception, the exception will be reviewed prior to the exception end date. If the individual requests the same or less exception hours, a decision to renew the exception may be made if section (3)(d) of this rule is not met. The case manager may supply the required documentation as outlined in section (4) of this rule.

(b) Exceptions may be reviewed at reassessments, change of situations, or change of conditions.

**Commented [RMG38]:** APD recognizes that for exception renewals that will most likely result in approving the same number of hours (or less) based upon ongoing needs of the consumer that have already been documented may not need the same level of documentation again.

Stat. Auth.: ORS 409.050, 410.070

Stats. Implemented: ORS 410.070

### **411-030-0072 Exceptions to the Homecare Worker Cap**

(1) A ~~consumer~~ individual receiving in-home service hours may be eligible for an exception to the hourly cap on homecare worker weekly hours as defined in OAR 411-030-0070(5)(b) and (c). if there are specific needs that are not able to be met by other homecare workers or providers.

(2) A ~~consumer~~ individual, or their representative, may request an exception to the homecare worker cap orally or in writing if the ~~consumer~~ individual believes their situation meets the criteria in (5).

(3) Exception to Homecare Worker Cap Application Process.

(a) Before processing an exception application for the homecare worker cap, the case manager must discuss alternative ways, if any, to meet the consumer individual's needs.

(b) After the discussion occurs, from subsection (a) of this section, a consumer individual may apply for an exception to the homecare worker cap by completing an Exception Application Form, available from the case manager, and providing any documentation required by the Department that supports the requested need for additional hours.

(c) The Exception Application Form for the homecare worker cap must:

(A) Be signed by the consumer individual, or their representative.

(B) Clearly describe the reason the homecare worker cap is not appropriate for the consumer individual.

(C) Include an attestation that all the information is accurate and truthful.

(4) All exceptions to the homecare worker cap in this section must be prior approved by Central Office.

(5) Central Office shall grant an exception to the homecare worker cap if:

(a) There is an insufficient number of homecare workers to provide the needed care to the consumer individual and no other resources are available, including in-home agencies, to meet the need;

(b) A homecare worker has quit or has been terminated. The exception is valid until a replacement homecare worker can be hired;

(c) The consumer individual is traveling out of town and needs just one of the homecare workers to accompany them;

(d) Relief or substitute caregiving services are needed and one of the following conditions are met:

(A) As a back-up when the primary or scheduled caregiver is unavailable.

(B) The situation is time-sensitive and would jeopardize the consumer individual's health and safety if the care for those needs is not received.

(e) There is an emergent or urgent need of the consumer individual; or

(f) The consumer individual has unique or complex needs requiring continuity of care.

(6) The Department may deny an exception to the homecare worker cap if the request does not meet the criteria in section (5)(a)-(f) of this rule.

(7) The Department shall notify the consumer individual about the outcome of the exception to homecare worker cap request.

(8) Notification shall include the reason the request was denied and provide information on hearing rights and how to request a hearing.

(9) An exception to the homecare worker cap that has been granted is valid for the period defined in the notice, not to exceed one year. Exceptions granted in subsection (5)(b) and (c) of this rule are time limited and may not exceed 30 calendar days.

Stat. Auth.: ORS 409.050, 410.070

Stats. Implemented: ORS 410.070