

**APD Rule Advisory Committee for OAR 411-015 and OAR 411-030**

## Summary of Meeting

**Date:** 07/25/18 1:00 PM – 5:00 PM *(ended at 3:30 PM)*

**Location:** Salem DHS Office

4074 Winema Pl, Bldg 53, 2<sup>nd</sup> Floor (Rooms 227-228), Salem, OR 97305

**Conference call in:** 866-390-1828; Participant code: 1369328

**Meeting Attendees (X= Attended In-Person P=Attended by Conference Line)**

	<b>Attendee</b>	<b>Organization</b>	<b>Contact Info</b>
X	Chris Angel	DHS APD MSS	<a href="mailto:chris.s.angel@state.or.us">chris.s.angel@state.or.us</a>
P	Darla Zeisset	DHS APD MSS	<a href="mailto:darla.p.zeisset@state.or.us">darla.p.zeisset@state.or.us</a>
X	Donitta Booth	DHS APD CTU	<a href="mailto:donitta.booth@state.or.us">donitta.booth@state.or.us</a>
P	Gordon Magella	DRO	<a href="mailto:gmagella@droregon.org">gmagella@droregon.org</a>
X	Gwen Dayton	OHCA	<a href="mailto:gdayton@ohca.com">gdayton@ohca.com</a>
X	Jane-ellen Weidanz	DHS APD LTSS	<a href="mailto:jane-ellen.weidanz@state.or.us">jane-ellen.weidanz@state.or.us</a>
P	Kimberly Colkitt-Hallman	DHS Rules Coord	<a href="mailto:kimberly.colkitt-hallman@state.or.us">kimberly.colkitt-hallman@state.or.us</a>
X	Mat Rapoza	DHS APD MSS	<a href="mailto:mathew.g.rapoza@state.or.us">mathew.g.rapoza@state.or.us</a>
P	Roxie Mayfield		<a href="mailto:roxie_mayfield@yahoo.com">roxie_mayfield@yahoo.com</a>
P	Tina Treasure		<a href="mailto:tintreas@comcast.net">tintreas@comcast.net</a>
P	Vanessa Pepe	Homecare Worker	<a href="mailto:vanessapepestar@gmail.com">vanessapepestar@gmail.com</a>

### SUMMARY

<b>Agenda Item</b>	<b>Discussion</b>
<b>Introduction</b>	<ul style="list-style-type: none"> <li>• Everyone introduced themselves; first people in the room, then those on the phone.</li> <li>• Request that each person say their name before they comment.</li> <li>• Taking minutes. Also, this RAC is being recorded.</li> </ul>
<b>411-015</b>	<p><b>Page 1</b></p> <p>Changes to 411-015 were made to clarify the intent of how to assess individuals and to provide more guidance to Case Managers when they are assessing people around our expectations. In this subsection around Bathing and Personal Hygiene, we are specifying that it is not just showers or bathing in a bathtub. It includes sponge baths, bed baths, etc. And it also includes bathing in a bathtub or a shower.</p>

Suggested change for Page 1:

- Lines 34-35, replace “bathes” with “bath” in the two occurrences

**Page 2**

Lines 14-17 The intent is to clarify all activities that are included in Personal Hygiene. When originally amended 015 rules, we meant to provide examples. We are being inclusive vs exclusive in the intent of the rule and giving examples of items that may be included in Personal Hygiene. Gwen commented on the narrow scope of Personal Hygiene and asked if other tasks that we normally consider ‘personal hygiene’ are covered elsewhere. Jane-ellen confirmed they are found in toileting and bathing. Gwen suggested we add the phrase “including, but not limited to.” Donitta suggested we add gum care. Gordon asked about hair care and dressing, and was pointed to dressing and grooming (which includes filing nails and hair care). Roxie suggested we add flossing teeth. Jane-ellen said we could define gum care and flossing in Personal Hygiene. Gwen stated that all of these would be covered by “including, but not limited to,” instead of having to list everything out; Jane-ellen agreed. Gwen commented that Grooming doesn’t say “washing hair” (as that is in bathing and showering). She suggested combining some of these. Jane-ellen agreed and said she would have Dressing separate, and everything to do with the body under a broader “Personal Care” or something like that.

Suggested changes for Page 2:

- Page 2, Lines 13-17, add “applying and removing makeup”
- Page 2 Line 15, replace “includes” with “including, but is not limited to,”
- Page 2, Line 16, after “dentures,” insert “gum care, and flossing,”
- Other suggestions from this conversation found under Suggested changes for Page 10.
- Consider keeping Dressing separate, and grouping everything to do with the body under a broader category of “Personal Care.”

**Page 3**

-We amended the overarching language around cognition (lines 8-14). Some people raised concerns that we were looking at prescribed medications. The intent was for us to look at how a person would be doing when they are taking their medications as prescribed (e.g., anti-depressants, anti-psychotic medications). But some people believed this was asking Case Managers (CM) to make a clinical judgment - and CMs are not clinicians. So that component was eliminated. CMs are assessing individuals, how they are functioning based on the way they are presenting at that moment in time, and looking

back in cognition (i.e., how they were presenting before interventions and how they would be with ongoing supports). So we are just taking that component out.

-Roxie suggested that we add “applying and removing makeup”; Jane-ellen said we would take that under advisement. [*Note: This comment was meant for Page 2, lines 13-17, on Personal hygiene.*]

-The changes on lines 16, 22 and 26 are just renumbering protocols. On lines 32-33, in Cognition, we changed from eight components to four components. The goal was to lower the threshold for individuals and make it easier for lay CMs to assess cognition. You are now either a Substantial Assist (needing assistance in one of four components) or Minimal Assist, etc. So we are just eliminating that one component, or requirement. Gwen suggested we change (d)(B), line 35, to “at least minimal assistance.”

-To clarify in cognition, (d) says, “To assess an individual as meeting the assist criteria for cognition”; that is not a driver of SPL 1 - 13. It doesn’t drive SPL at all. If the consumer is assessed as having a need in cognition, it lets us assign hours to the consumer. That’s the purpose. So if we redefine that, we need to be clear that this is the criteria; that the consumer will be eligible for at least some hours for services, even if it doesn’t impact eligibility.

Suggested changes for Page 3:

- Line 35, insert “At least” before “minimal assistance”
- In 411-015-0006(3)(d), we may need to reference 411-030, or add something that references why we are defining Assist differently here than in the rest of the rule.

**Page 4** Renumbering.

**Pages 5 – 8** No substantive changes.

**Page 9**

On line 37, under dressing and grooming, we changed the language to provide more clarity and capture the entirety of Dressing. This carries over to 10.

**Page 10**

The goal for Medicaid funds is to pay for services that are needed, not just wanted. But we also don’t expect people to only have to wear a robe, or only wear partial clothing. If they want to wear jeans and a t-shirt, then they should be able to wear that. If they want to wear specific under clothing, then they should be able to wear them. The goal here is to compare the needs of individuals to the needs of people without limitations, to ensure that we are giving people the choice of how they want to dress. If all someone wants to wear is a robe or a housecoat, then that is their choice.

But if they want to be dressed (in whatever manner), then we are performing those activities and assessing those needs of those individuals. Gwen commented on the assist level (Assist/Full Assist here vs. Minimal Assist, Substantial Assist and Full Assist in Cognition). Jane-ellen explained that we have ALJs saying we were inappropriately giving hours to consumers with cognition impairments in other areas, because they were not a Full Assist in Cognition. ALJs were looking back at the Eligibility rules instead of the Service rules. To make it clear for everyone, including ALJs, we needed to talk about Assist. Cognition has Substantial Assist and Full Assist and that is a component. There is a linkage between the -015 and the -030 on cognition. This is intended to define how we assess for a consumer's eligibility for SPL. Gwen asked if it is for the hours, and Jane-ellen confirmed it is. Gwen referred to page 3, where we talk about Substantial and Minimal Assist but there is no reference to Full. Jane-ellen explained it is because this section is about the hours. Jane-ellen suggested on page 3, for 411-015-0006(3)(d), we may need to reference 411-030, or add something that references why we are defining Assist differently in Cognition than in the rest of the rule. -Grooming means the components of nail and hair care. Here we define what hair care is, which is different than washing your hair (found in Bathing). We wanted to give examples here, too, so the CM cannot say that just combing or brushing someone's hair is good enough. Grooming is what the person needs to have in maintain their hair, and having it done in the manner they choose to have it done. Donitta asked about filing a person's nails. Mat clarified that filing and trimming are part of grooming. Gwen suggested adding "including, but not limited to," here (lines 17-18), as well. Donitta asked about filing one's nails. Mat clarified that filing is trimming, which is part of grooming.

Suggested changes for Page 10:

- In OAR 411-015-0006(3)(d), we may need to reference 411-030 as to why we are defining "Assist" differently in Cognition than in the rest of the rule;
- Lines 17-18, replace "includes" with "including, but is not limited to,";
- Lines 18-19, replace "includes" with "including, but is not limited to,";
- Line 19, add language for scalp care.
- Consider putting Grooming and Personal Hygiene together.

**Pages 11-12** No substantive changes.

**Page 13 – 14**

At the bottom of page 13, we've added, "This" and continues on the top of page 10. We are providing guidance for our more literal CMs who assess things in ways we did not intend the rule to be read. For example, if an individual can transfer out of their four-wheel walker, but can't sit on any furniture or transfer out of a bed, he might have been assessed as independent when that is clearly not really what is happening for that individual. We've been working for quite some time on defining repositioning, which is found in lines 5-6. Repositioning is not just for people in bed; it is also for people who need repositioning in their wheelchairs, as well. Gordon asked where transfers in/out of vehicles is found. Jane-ellen said it is in transportation. She shared an example of a person who falls and takes 45 minutes to stand up every time it happens. That's not reasonable, and we would say that person needs assistance. There's a reasonableness and comparability to people who don't need assistance.

**Suggested changes for Page 14:**

- Line 5, insert a comma after "wheelchair"

**Page 15**

We took out behavior. In cognition, we used to assess five parts of Cognition and three behaviors. Since we really don't assess behaviors separate from Cognition at this time, we're removing that word.

**Page 16**

We have an expectation that the consumer participates in gathering information and assisting us doing a complete assessment of their needs. We are clarifying that this expectation is not just for the initial assessment, it's also for reassessments. This language clarifies that we're talking about every time we do an assessment or reassessment. Gwen noted that this places an obligation on individuals over whom the Department does not have jurisdiction, and asked what the consequence is for somebody who doesn't participate. Jane-ellen explained that we can close their case or deny their services if they do not participate. Of course, we make every effort and give them every opportunity. We then send a notice that we are going to schedule, at their convenience, with anyone they want (also called the Buckley Notice), and offer an opportunity to ask for extensions. If they refuse and are non-responsive, then we can close their case. Gwen asked about the person who cannot participate. Jane-ellen clarified that this doesn't mean the person must participate if he is cognitively unable – but that they have to be willing to let us come in and do the assessment. This will cover consumers

who have refused to let the CM to come in their house, or have moved and don't tell us where they've moved to. Gwen asked for confirmation re: facility providers, that it means they should not accept anyone who refuses to participate. Jane-ellen said Gwen was correct. Donitta asked if a person would still get notice; i.e., the State will not just stop paying. Jane-ellen confirmed they would still get due process rights, and we'd notify the provider that we would be stopping services.

Gordon had two questions: (1) Do you think it would make sense to have some sort of due diligence provision here that will talk about the Dept's responsibility to take reasonable efforts to secure the participation of the individual? Gordon thinks there is some burden on the Dept to do that, but doesn't know how that works out in the real world. Gordon thinks if APD has a consumer who says, "I don't want to do the assessment. I know what I'm doing. I don't care if I lose my services," he doesn't think the Dept is obligated. But Gordon does think there may be an obligation to try to track somebody down who has moved. Or for any number of other reasons he is not engaging in that process. Gordon said this strikes him as the thing that really impacts the most vulnerable folks; people with transient housing, or people with really weak natural support networks, or those situations where the Dept may be having trouble tracking someone down, or have some family members inserting themselves into the middle of things and pushing somebody in or out of services. (2) How much responsibility does the Dept have to really make sure that the consumer really knows what's at stake, or that DHS really made the best effort to do the assessment, and absolutely cannot track a consumer down - or the consumer really is, of their own volition, saying, "I don't want to participate in this assessment process."

-Mat's hesitation is that CMS requires us to do annual assessment. What we want to avoid is, say the consumer is failing to participate, we can't find them - whatever the case may be. We would hate to prolong it, when it's one month, two months, three months out, because we are now violating CMS statute by not doing the assessment on an annual basis. We've got to be careful on putting cases out in perpetuity. We have to make a decision at some point. Jane-ellen believes that a Medicaid consumer, in their consumer responsibilities, has a duty to let us know when they have moved and keep their address up-to-date with us. She agreed that it is the Dept's responsibility to do everything we can to do the assessment. But if the family is overly inserting themselves and we believe it's leading to neglect or some level of exploitation, then we get our APS system involved. In general, we see the flip side - these people are no longer eligible and they think that if

they delay interaction with us, they will continue to receive the services that they want. We will take this back and discuss it further. Perhaps we could include language around due diligence that doesn't put us at risk or violate the Medicaid consumers' responsibilities. The Buckley notice language is on the bottom of page 15. Jane-ellen believes the necessary language is in these rules. Mat explained that we want to honor the preferences of consumers. So that's why we put extra examples in these rules. We want CMs to look at all the criteria so they can give the appropriate Assist level. We are hoping this will help. Tina believes the clarifications used by the examples will make it easier for the CM and even for the consumer to understand what CMs are looking at when being assessed; the changes were really good and really consumer-based.

Suggested changes for Page 16:

- Look at including language around due diligence that doesn't put the State at risk or violate the Medicaid consumers' responsibilities.

**Page 17** No substantive changes.

**411-030**

**Page 1**

Many of the changes are housekeeping. We no longer do the acronym as the definition; we include it in the definition. For example, "AAA" is now "Area Agency on Aging (AAA)". Gwen pointed out that (2) APD on line 25 was missed. Jane-ellen agreed we need to change that.

Suggested changes for Page 1:

- New #2, lines 25-26, change to, "Aging and People with Disabilities (APD)" means the program within the Department of Human Services. *Maybe add further clarification at the end of this definition, such as, "...that serves people who are aged or have a disability."*

**Page 2**

Jane-ellen shared that we realized we do a lot of procedures with CMs around how we talk about the actual service plan for individuals, and when they start and when they end. We are now ending everything for service benefits or starting benefits based on the service period for HCWs for in-home consumers; so we needed to define it in the rules. The intent is to define how we're authorizing services. Mat said we use the term "benefit plan" in OAR 411-030-0070 (page 14). This is terminology we have not specifically used before, so that's why we wanted to define it here. Gwen mentioned that in definitions, you generally don't want to include substantive requirements. "The Benefit Plan allows the services to be

approved for the consumer,” is not really a definition; that’s somewhere else when you’re talking about consumer involvement. Perhaps it could say, “The consumer shall be allowed to participate in the development of the benefit plan,” or something like that. Gwen clarified that you can’t enforce a definition; the first sentence is the core of the definition. If you want consumers to participate in the development of the service plan, that’s a requirement. If you put it in the definition, you can’t enforce it. Jane-ellen explained that it is really an administrative process. At this point, the service plan has already been accepted and approved by the consumer. The benefit plan comes in when we turn it on, when we hit “submit” in the system. We can look at where that would be.

-Mat said we crossed out the definition for CA/PS (lines 17-18) because we define it later in new #11 (line 31). In new #9 (lines 20-26), we define Case Manager. But for the purpose of this rule, CM also means anyone that is classified as a Diversion/Transition Coordinator. So if we say CM, we mean that classification, as well.

Suggested changes for Page 2:

- Lines 9-12, look at moving the 2<sup>nd</sup> sentence out of the definition into (somewhere else); or say, “The consumer shall be allowed to participate in the development of the benefit plan.”

**Page 3** Renumbering.

**Page 4**

We added APD in new #18 (lines 1-2) because we mean “us” not everybody else in the Dept. Mat explained that we crossed out -0070 in new #23 (line 27), and replaced it with -0071 because the exception rule language is now housed under a new rule. Gwen said that’s her primary area of confusion, when we get to that rule.

**Page 5**

Mat reminded the group that we are still looking at the definition of exception. We will talk about shift services a little bit later as part of exceptions. Shift services is defined here as 16 hours per day of care if it meets the criteria found in 411-030-0068. Exceptions are allowed for shift services to go beyond the 16 hours per day. This talks about all the different types of exceptions that are out there. We wanted to clarify that we do offer exceptions even beyond the 16 hours per day of shift services. Jane-ellen said we realized the language “Exceptional rate” or “exceptional payment” (line 4) was carried over from other parts of our system. But In-home exceptions is only about hours. We don’t provide additional money as an exception; these exceptions are for the number of hours it takes to provide

care to an individual. And then we have contracted rates for In-Home Care Agencies or collectively-bargained for HCWs. So we took that language out to clarify that we are talking about hours for in-home consumers. Gwen asked for confirmation that the payment follows the hours. Jane-ellen confirmed this is correct. People were misinterpreting it as that State would give extra money to HCWs for people with greater needs, but that is incorrect. If the HCWs hours are increased, the HCW will get more money in gross wages, based on the number of hours to cover the consumer's needs. In new #27 (line 21), we added the acronym HCW to "Homecare Worker".

### **Page 6**

Skipping down to new #34 (lines 31-36), we changed the definition to clarify what in-home services actually are. Gwen noted that the substantive change was that the old language said it 'allowed them to stay' and now it says 'while they are staying.' Jane-ellen confirmed this. She said we are not making a value judgment. It is the consumer's full choice – to choose whether to stay in their own home and receive their services. Donitta asked what happens if the consumer is not in their own home or living with a relative; what if they live with a friend? Mat explained that our rules define what dwelling requirements are, and living with a friend is considered living in their own home. Jane-ellen further clarified that if they are living with a friend, and their friend is not providing the care, then they are fine. We have it all spelled out in rule about what is considered "home." The reason we spell out 'in the home of a relative' is because we used to have a policy (that we changed years ago) that basically said a consumer could not live in their family's home unless the consumer was on the lease, mortgage, or rental agreement. That policy was limiting consumer's choices to stay with their family; and it was not where we wanted to be with our policy. Gwen wondered if staying in the home of another person is weakening that argument. Jane-ellen suggested we take out "living in their own home as defined by..." Mat suggested we cite the rule instead. The group liked this option best.

#### Suggested changes for Page 6:

- Lines 35-36, where it talks about where the individual is living (in their own home or in the home of a relative), say something instead, to the effect of "...as defined in 411-030-0033."

### **Page 7**

The new definition is "Preventative" means services and supports that don't meet the definition of the ADLs. We want to be very clear that what we are funding and able to fund in the Medicaid program are the services that are

defined in 411-015, and the tasks that are defined in those rules. Gwen finds the term “preventative” funky, as some things that don’t qualify as meeting the definition of an ADL aren’t preventative at all. They’re just not on the list of things that are covered. They don’t fall under the grouping for some reason. Jane-ellen clarified that this is more like, “I want someone here. I don’t need assistance, but I want someone here.” While Gwen understands that, she pointed out that that’s not how it’s defined. Donitta does not understand the last sentence in the definition. Jane-ellen explained the definition includes the tasks and assistance types. As an example, supervision is allowed in cognition, but it’s not allowed in mobility. Range of motion is not considered one of the tasks, so that would be not included in what we’re providing in in-home hours. Mat double checked why we inserted this - specifically, why now. We use the term ‘preventative’ later on when we get to the exception rules, so we needed to make sure we have a definition for it. We will cover it soon, but we’re basically making it very clear in the exception rule language that exception hours are not utilized for preventative care; it’s meant for ADL/IADL care. Gwen understands. She stated the substance of the definition works fine. Gwen said not all things in that don’t meet the definition of an ADL are preventive. Donitta and Gwen suggested new language to the effect of, “Services intended to delay or prevent...” Gwen said this is more than “services that don’t meet the definition of an ADL”; there are a lot of things that don’t meet the definition of the ADL that don’t prevent anything. Preventative services are a portion of the entire field of things that aren’t ADLs that are beyond the allowed benefits. Jane-ellen suggested that we talk about this further when we discuss preventative in the upcoming rule. We may change this definition to include, “...only providing these services and supports and not providing preventative services.” We can look at it when we get there.

-Vanessa asked to go back to Natural Supports, new #38 (lines 12-18). She stated that she doesn’t remember signing anything saying that she was willing to help [a certain individual] with their needs. Vanessa went into specific details about her situation. Vanessa stated her concern is that it’s not a reasonable plan of care. She didn’t sign anything saying she stated it was a reasonable plan of care. She believes the State presumed she was ok with becoming a natural support. Jane-ellen asked Vanessa to stop speaking about a specific individual’s situation in a public meeting because that violates confidentiality for the consumer. Jane-ellen offered to talk to Vanessa offline. Vanessa said she would stick to public words. She asked how the State determines that a person is voluntarily providing services without

an expectation of compensation, when the natural support is not given another option. The State says, "This is the maximum number of hours that a person can have." Jane-ellen explained that we have an exception process that can be used by the individual or their representative, if they believe the plan/hours don't meet their needs. Vanessa shared personal information again. Jane-ellen and Mat interrupted and reminded Vanessa that we are unable to talk about anything personal. Jane-ellen clarified that we don't want Vanessa to get in trouble because as a HCW, she could - for violating confidentiality.

-Vanessa said she understood, and read an excerpt from a US Dept of Labor law that says, "A reasonable plan of care under domestic service," which, it does say HCWs are domestic service, it says, "a determination of reasonableness will take into account whether the plan of care would have included the same number of paid hours if the care provider had not been a family or household member of the consumer. In other words, a plan of care that reflects unequal treatment of a care provider because of his or her familial or household relationship with the consumer is not reasonable."

Jane-ellen confirmed that is the policy. The individual care provider needs to be willing to provide the natural supports, or not, and the consumer needs to be willing to accept them. That's defined in the service plan. But if a consumer is living with a family member and the family chooses to provide services beyond what the State authorizes, they can do that. In most situations, we don't provide supervision or stand-by care - so sometimes family members choose to do it. When a CM is discussing the assessment with the individual or their representative, they will go over the needs that have been assessed and the number of hours that are authorized to meet those needs. If the individual or the representative think they need more hours, then they can request an exception. The Dept still has the ability to approve or deny the exception request. If that occurs, and if the consumer disagrees, they go to hearing. And if the court sides with the Dept, we implement what the court has decided. To that individual, or their family, it may feel like they are being asked to perform mandatory natural supports. But the Dept has assessed the individual and determined what they are eligible for based on their assessed need. If the family decides to provide more supports, they're doing that through natural supports. Vanessa said the 'natural supports' definition does not clearly state what the Dept expects of natural supports.

-Vanessa asked what the definition of cognition is. She believes all the cognition definitions support the fact that if a person needs supervision and

standby care, they are paid hours. Jane-ellen confirmed that they are (as she stated before; they are in most of the ADLs); cognition is one of the exemptions. Mat clarified that monitoring is the only one for cognition. Jane-ellen mentioned that bathing allows for stand-by, but cognition is the only one that has an exemption for monitoring. If the individual has excessive cognition needs, then they would be potentially eligible for an exception in cognition. But if a case has gone all the way through the exceptions process and has been denied, then the Dept is saying that there is no need in that area. Vanessa and Jane-ellen discussed how/why the Live-in program was eliminated by the Legislature – despite, as Vanessa emphasized, the need for many people to have 24-7 care. While Vanessa thought it was due to a contractual issue, Jane-ellen explained that the Legislature eliminated the funding for that program and directed the Dept to close the program as it was no longer sustainable due to US Dept of Labor changes. However, there are alternatives. Jane-ellen explained that an individual who has high needs can receive an exception. We will serve people in their own home up to 24 hours a day, but they have to have needs that meet the required criteria. And if they don't meet the criteria, they are not eligible. Vanessa shared her hope that this new process, having people qualified to assess the situation better, will help her situation because it is unsustainable. Vanessa thinks the expectations of natural supports are unclear in the definition. And the fact that they're "willing" and "voluntary" – I do believe that should be in writing. Mat wanted to make it very clear that there is no expectation to have people do work that they are not willing to do, or do not wish to do, without compensation. We're not going to force anyone to be a natural support. We cannot do that. Mat gave an example: An individual has a need for a large number of hours. We can authorize those hours. But there is a limit to the number of hours a HCW is legally permitted to work – 40 or 50 hours per week. If the current HCW can't cover all the hours, the additional hours would have to be covered by an additional HCW, or two HCWs, or an In-Home Care Agency (whatever the case may be) to provide care for all those additional hours that exceed the limit of the first HCW. We have some consumers who have six or seven caregivers (between HCWs and In-Home Care Agencies) because they need a lot of care. We work with the consumer and make it work so that several folks are coming in to provide the care so that no one is being forced to work as a natural support. But everyone is working, they're just working up to the maximum number of hours they are legally allowed to work. Vanessa began to discuss a personal situation. Jane-ellen cautioned her again and said Mat and she would follow up with

Vanessa after the RAC. Vanessa requested that 'willingness and voluntary' in the definition of Natural Supports be spelled out; say exactly what is expected of a person. Vanessa wants the State to be really clear about the number of hours not being covered by the State, and what is being left to the primary caregiver providing natural supports. Jane-ellen thought that was a good point.

Suggested changes for Page 7:

- In the definition of Preventative, include something like, "...only providing these services and supports and not providing preventative services."
- Line, in the definition of Natural Support,
  - Clearly state the expectations of those providing natural supports;
  - Include requirement that willingness and voluntary are spelled out in writing;
  - Be really clear about the number of hours not being covered by the State, and what is being left to the primary caregiver providing natural supports.

**Page 8**

In new #50 (line 30), Gwen asked why we use the specific period of 16 hours of services – not 15, not 17. Jane-ellen clarified that shift services are defined as 16 hours a day, because the individual needs awake care - at least one service provided every single hour during that awake period. If the consumer needs more care than that, they shift over to an exception on top of their shift services. Regarding the last sentence (lines 31-33), Gwen believes this is not actually a definition of shift care services; it seems like it should go somewhere else. Jane-ellen and Mat agreed.

Suggested changes for Page 8:

- Line 34, remove the 's' at the end of "assistances"
- Lines 31-33, move this sentence elsewhere.

**Page 9**

The biggest change here is, back to natural supports, we used to actually deny people Medicaid eligibility if natural supports were performing all of their services. Gwen clarified were performing, or could perform. Jane-ellen confirmed this. However, that is not the way we have implemented policy since we filed the 1915k. This was old waiver language; so it's out. And the rest on that page is just clean-up.

**Page 10**

We've eliminated language (Lines 9-36). If a consumer or representative did not engage in long-term services and supports within 14 days (they didn't hire a HCW, they didn't participate in finding an In-Home Care Agency, or they didn't find a provider in the Independent Choices Program), we would close them. It's long-standing policy because CMS would say that individuals who are not accessing services for extended periods of time needed to be closed. We think that 14-days doesn't accommodate the needs for finding a HCW, getting them through the criminal background check, etc., so we are removing that language.

**Pages 11-13** No substantive changes.

**Page 14**

We've clarified language in (2)(a) (lines 21-22) and removed "time allotments" since nobody uses that term anymore. Through negotiations with legal advocates, we have restored the former maximum hours that consumers used to be able to receive, to the previous numbers. There was a short time that the number of hours were reduced, and now they are back. But they are also converted from monthly to two-week service authorizations for ADLs. All the way through, you'll see the maximum hours by assistance levels; it is all restoration of hours. Gwen asked where the two-week authorization is expressed. Mat pointed us to page 8, where "Service Period" (not "Service Authorization") is defined. We will change occurrences of "service authorization" to "service period".

Suggested change for Page 14:

- Line 22, replace "authorization" with "period".

**Page 15**

We've changed the hours in all of the ADLs expect for Elimination (lines 23-29) and Cognition (lines 31-37) because we had increased those hours; so we didn't go back and reduce these as they are higher.

**Page 16**

In the past, we were very prescriptive; CMs used to be able to reduce the maximum hours they were authorizing for "Case Manager Determination." Over the last year, we've been defining in both rule and training that it is more limited than that. It's not just arbitrary. There is a defined reason why hours are being reduced. To clarify this even further, we use the phrase 'one of the following' (line 12), (A) through (E). So it's taking out any arbitrary reasons. Gwen said when she read it, she thought, "Ok, you can authorize fewer hours for one of the following... not two, only one." Sometimes more than one may apply. Chris suggested, "at least one." Mat offered, "any of"

and Gwen and Donitta agreed. Referring to (A) (line 15), Gwen asked, “of what?” Donitta stated, “of the need” and Gwen agreed. Jane-ellen suggested we add language to the effect of “of an ADL need” after “duration”. When we get to the next section, it will be “of an IADL need”.

Suggested changes for Page 16:

- Line 12, replace “one” with “any”;
- Line 15, after “duration” insert “of an ADL need”.

**Pages 16-18** No substantive changes.

**Page 19**

Jane-ellen reminded us that we will be making the same changes from page 16 (re: ADLs) here for IADLs. Gwen raised a question about people living in same house. It says when more than one eligible person lives in the same household and receives services, the number of hours cannot exceed 24-hours (line 30). Gwen asked if we mean total hours, between all people living there; if so, you need to add “total” before “number”. Let’s say you’ve got a husband and wife. They are both receiving services, and maybe a disabled son. So, is the concept the total number of hours for that household is 24, not for any individual person? Jane-ellen said, “Right.” Gordon said he’s been curious about this rule for a while. In a sense, it makes sense that if you have people with a certain level of need, you don’t need to be having households that have a lot of overlapping hours. But how do you address the scenario in which you may have a husband and wife, and both have significant needs - both on ventilators, for example? (or something like that – both require at least more than 12-hours a day of care? How are you addressing those situations? Are you looking at that as an exception? Jane-ellen answered that it is an exception. We do have a few of these. But in general, since a large part of the hours are IADL hours, you end up with two people doing housekeeping, two people doing meal prep, and so you need to look at each one of those specifically. We may have, for example, someone with specific dietary needs and it takes two people to get the food to the individual. But it’s really more of a focus on what their ADL needs and making sure that you are meeting the entire needs of the individual in the home. We have a situation with two individuals - both need 24-hour care; they both have quadriplegia with ventilators. They each get all of the ADLs to meet their specific need and then they are sharing the IADL hours. Gordon believes this is a reasonable approach, especially in that scenario. He pointed out, however, that this rule doesn’t say that. He said in a household of two people, it would automatically be the exceptions process to get 24-hours for either of them. Gordon questions whether there should be some type of

clarifying language. Jane-ellen suggested we add language here like we did in the shift language that says something like, “an exception may be granted if the consumer... per 411-030-0071.” We will look at that. Gordon thinks that is reasonable and understands most people in this 24-hour cap situation would almost always have already been in exceptions process anyway. He thinks this is a helpful addition.

Suggested changes for Page 19:

- Line 13, replace “one” with “any”;
- Line 16, after “duration” insert “of an IADL need”;
- Lines 29-32, add language to the effect of, “an exception may be granted if the consumer... per 411-030-0071.”
- Line 30, before “number” insert “total”.

**Page 20**

-This goes into service planning with the consumer. In #6 (lines 15-19), the HCW can't just decide to work more hours. Everything has to be prior authorized. But if it's occurring at night, or on the weekends, then we also allow the HCW to work the minimum necessary to meet that need, and then get approval within two business days. This is intermittent, it's not permanent. It is really intended to be for (for example) the consumer had a stroke and you are waiting for 9-1-1, or the consumer can never be left alone per the assessed need in the Service Plan, and the relief care giver doesn't show up – and there is no one else, no natural supports, or there is no one else to come in. It is really intended to cover emergency situations.

-Gwen shared her confusion on two points. First, how do (6) and (7) relate to the exception process? Second, how do (6) and (7) relate to each other? When Gwen read this, she had just finished the exceptions process section. Then she got to this part, and it says (in (6)), HCW, which isn't an In-Home Care Agency (IHCA). Then it refers you back to (5), which talks about shifts, and that you can't work more than 40 hours a week if they are prior authorized. Gwen asked if you'd have to have an exception to go past the 16 hours. Mat answered that on a regular service plan, yes. But what this is intended for is, as Jane-ellen was describing, if an emergency happens and there is not enough time to do an exception request and approval (e.g., it's a Friday night and there is no one else around). We wanted to make sure that if it is truly an emergency and the provider has to work and there is not enough time to ask for an exception, and they are going to end up working above their cap, we are willing to authorize additional hours if they were necessary during those emergency circumstances. Donitta suggested adding “in an emergency” at beginning of (6) (line 15). Jane-ellen added, “in

emergency situations". Gwen suggested inserting "(b) and (c)" after "(5)" on line 16. Jane-ellen proposed an alternate solution of inserting "or they were provided in a life-sustaining work" after "Department" (line 17). Gwen believes we should reference the exception process here, because otherwise we lose the trail of what we are talking about. Donitta asked if we really need the first "authorized" (line 15). Mat agreed that it should be removed. Gwen also agreed because we are using "authorized" in two different ways. Mat agreed we should focus on emergency situations and not on being prior authorized. Gwen inquired if the prior authorization is part of exceptions. Jane-ellen confirmed this and read the newly proposed language for (6), "In emergency situations when the Department is not available to approve an exception: (a) A HCW may work additional life sustaining hours but must notify the Dept within two business; or (b) May work more than 16 hours a day during a 24-hour period." Gwen suggested the inclusion of "or unanticipated need (or event?)" after "In emergency situations". Jane-ellen and Mat agreed that we should flesh that out.

-Jane-ellen explained that in new #8, we are adding that this section may be waived if the criteria in (6) (lines 29-30) are met. So if there is an emergency situation, we are going to pay the HCW. Perhaps we roll all of these things (i.e., subsections (6)-(8); lines 15-30) into one paragraph. Gwen would like to replace "may" with "shall". Gwen asked that we not roll subsection (8) into the new subsection (6)/(7), as (8) is a big statement. Jane-ellen agreed. Gwen suggested we include all the circumstances where you might get paid, even if the hours are more than the service plan because you've gotten an exception authorized. Jane-ellen said that is "authorized"; but then there is the exception. Gwen asked about whether the exceptions are on the service authorization form. Jane-ellen and Donitta answered that they are, for both IHCA's and HCW's. We don't call it out as exception hours, but it says, "this is what you're authorized." What we are trying to say here is that if you are authorized for 10 hours a day, but you are choosing to work 16 hours a day – and we haven't defined that as a need for the individual – we are not going to pay you. You are making a choice to do that.

-Gwen asked for confirmation that (6) and (7) only apply to HCW's, not IHCA's; and if so, whether we have comparable language for IHCA's. Jane-ellen responded that (6) and (7) are for HCW's, not IHCA's. HCW's are authorized to provide a certain number of hours. And your licensing rules require, for IHCA, them to have backup plans and methodologies in place. The direct responsibility is to that provider. Whereas we are paying HCW's directly as a joint employer. These rules are mixing the service component for the

consumer and the requirements for Medicaid providers with whom we are joint employers. Gwen presented a scenario where a person has a sudden health event when the person from the IHCA is supposed to leave. That person would not humanely leave and so they stay. But the agency wouldn't be paid for those additional hours? Jane-ellen said it would depend on – say the person had pretty low needs and they have a heart attack and the person is waiting for 9-1-1 to get there, so they stay. But they aren't going to be home tomorrow, so you are not showing up tomorrow. So they are just billing to the maximum hours that were available over that monthly service. Gwen asked what would happen if they went over their max hours. Jane-ellen said they would talk to the CM and ask for additional service authorization. It wouldn't have to be prior authorized, unless it is the last business day in a month and they've already maxed all their hours. Gwen asked if they can ask for more hours retrospectively. Jane-ellen clarified that, in general, if they are saying they've used all the hours available (or we think we are going to use all the hours for this consumer early this month because of this event), the CM would then authorize more hours or ask for an exception to authorize more hours for an IHCA. The only place it may be odd is if it's the last day and you've already provided all the services. But we can look at the IHCA authorization rules (OAR 411-033) to make sure that we've captured emergency situations. Gwen liked that suggestion, as there may be events – like a fire – that happen; sometimes things just happen.

Suggested changes for Page 20:

- Line 15, after “(6)” replace “A” with “In an emergency, a”;
- Reference the exception process in (6) so it ties this section to exceptions.
- A. Line 16, after “(5)” insert “(b) and (c)”; **or**
- B. Line 17, after “Department” insert “or they were provided in a life-sustaining work.”
- Line 16, delete “be authorized to”;
- Consider combining (6) and (7) [*which means the rest of the subsections in this rule will need to be renumbered*] to say:  
“In emergency situations or unanticipated needs [*or events?*], when the Department is not available to approve an exception, a homecare worker may work: (a) Additional life-sustaining hours but must notify the Department within two business days; or (b) More than 16 hours of hourly services during a 24-hour work period.”

[Chris: (1) Is the inclusion of “exception” here clear? Maybe we should further clarify it... like, “approve an exception to the HCW’s hourly cap”; (2) Isn’t the HCW supposed to be approved/authorized by the Dept for (b), or do they have to let the Dept know within 2 business days for this, too? I think we are missing something. What if we add “if the Department has already authorized the request” to the end of new (b)?]

- Line 29, replace “may” with “shall”;
- Lines 26-30, include all the circumstances where you might get paid, even if the hours are more than the service plan because you’ve gotten an exception authorized.
- Look at OAR 411-033 (IHCA rules) to ensure we’ve captured emergency situations.

**Page 21**

We have eliminated everything about exceptions to maximum hours (lines 6 – 33) because we’ve moved the entire process to its own subsection in the rules. More to come on this. We’re defining Extended Waiver Eligibility (line 36) and referencing OAR 411-015-0030.

**Page 22**

Now we get into the exception rules. Jane-ellen explained that in discussions with legal advocates there was grave or significant concern that in-home exceptions process was opaque to consumers and hidden. The intent has always been that it is the CM who understands maximum hours rules; they understand what they can do and what they can’t do, etc. We were empowering CMs. But through the discussion with the legal advocates, it was really clear that we needed to be more transparent, and we needed to continue to empower the CM to ask for an exception, but to also give the consumer the ability to ask. It’s not the provider. It’s the consumer, or their representative (Rep), who is put in the driver’s seat. It is also not intended to be, “Oh, this is just the consumer. If the consumer doesn’t ask or fill out our form right, then they are not eligible.” It is really supposed to be a partnership between the consumer and the CM, with some responsibilities on both sides to make sure the exception is legitimate, that it’s defining and meeting the needs and the expectations of what we can do. And then this is clearly defining that we are giving consumers due process rights that if we deny an exception, they can appeal it. It used to be at one point in the past exceptions were never hearable; but now they are. We wanted it really clear and spell out current processes in rule so it is transparent to individuals and advocates about what we are doing and the expectations.

-Gwen said this gets to her earlier concern about the private provider. Mat stated that to be clear, if for some reason we are not fully approving a consumer's request for an exception -anything at all- we are going to explain why we did not approve the exception. So the consumer can ask for a hearing if they don't think that's right. We make it very clear to the consumer why (if we denied it, for example) we denied it and 'this is how we came to the conclusion we did'. It is very clearly spelled out to the consumer now, much more than ever before – which is a great win for our consumers. Jane-ellen clarified that just because someone has asked, doesn't mean they will get it. It still needs to meet the definitions of the activities of daily living, including the tasks and the assistance types; and it has to meet our expectations around reasonableness. An example was an exception request where they were doing bowel care for an individual and it was taking nine hours a day. That is a long time. What we found out was the gentleman was having health problems that needed to be addressed through medical interventions vs. an exception that was limiting his ability to participate in society. We are going to look at things in a lot of detail to make sure that these are really legitimate needs and that they are in the best interests of the individual. That is what we have in front of us.

-Gwen stated OHCA doesn't oppose this in the slightest. However, they have experienced overburdened case managers. The hope is that we can be mindful of how this is working in the system, that it doesn't start poking its way of other areas - like things don't get entered into MMIS because this CM is ready to jump off a bridge. Jane-ellen responded this process is really the same as what has been expected but it was really all process and procedures vs. transparent. There really are two big changes: (1) The consumer now needs to sign the exceptions form that what they are asking for is legitimate and a true need; and (2) The consumer can ask for an exception. In general, many consumers didn't know that they could ask. The biggest change to CMs compared to before. We're not overburdening them, as this high threshold has been the expectation for a decade, if not longer. Mat said it also makes it clear that the consumer drives the process for an exception. And if they want to ask for it an exception, they can. It's not up to the CM to disagree or that the consumer is asking for more than is necessary. A conversation should happen between the CM and the consumer that hours are meant for ADL/IADL needs, not preventative care or 'just in case'; it's meant for actual time spent providing care. Those conversations should happen. But even beyond that, if a consumer truly wants an exception, they have a right to request it and then a right to have a decision made on that request, too.

-We broke this out into subsections that cover every step of the process. We tried to make it as detailed as possible, to make it clear what we do. We are not going to read everything verbatim because that is a lot to read. But we will summarize the changes are in each section and then address questions.

-In section (1)(a) (lines 6-12), if the Dept feels a consumer needs an exception, we will grant one to the maximum hours in either the ADL hours or the IADL hours. Section (b) (lines 14-18), we wanted to make it very clear that we are also doing exception hours within cognition. Donitta thought the main difference is that in cognition, we can give exceptions to other ADLs that affected by cognition, whereas in (1)(a) it is only for that specific ADL. Donitta suggested we add "specific" before "ADL" and before "IADL" (line 12), which would make the distinction clear between the two. With (1)(a), the exception is per specific ADL/IADL. In (1)(b), the exception under cognition could be for other ADL/IADLs that are affected by cognition. Jane-ellen shared that there was a rumor at one point that has permeated some areas of the State where people thought that you couldn't ask for hours for exceptions for cognition. To be very clear, we will give hours for cognition to make sure the individual is safe and that their ADL needs are being met. Vanessa asked if it is true that there are a certain maximum number of hours for cognition, and then there can be additional hours because each ADL or IADL needs extra care because of cognition. Jane-ellen gave an example of a consumer who is afraid of water and is combative during bathing – so it takes either two people to help with bathing or it takes longer to bathe because of that. We would give them hours in bathing. But then if the individual also needs supervision and can never be left alone because they pick up knives and do bad things with them, and can hurt himself or others, we would also be giving hours specifically in cognition. Vanessa asked if those are beyond the maximum number of hours listed for full assistance. Jane-ellen confirmed that is the case and clarified that they are determined on the Dept's assessment on the needs of the individual. Vanessa asked if (for example) the 12 hours for mobility is not really the maximum; i.e., can there be some additional hours to mobility based on cognitive needs around mobility. Jane-ellen said that is correct. If the individual is wandering and is a danger to himself while out in the community and would need to be supervised so that they don't wander and get hurt, that would be in cognition not in mobility. Vanessa asked how the CM will recognize that cognition hours need to be added to each task. Jane-ellen answered that when they are asking for exception hours, they put it in based on what the consumer and/or representative is saying - where there are needs. And

when we are reviewing it, we'll have a discussion with the CM – looking at where they have put the hours and have them explain it. If they put it in the wrong place, we'll have them correct it. In cognition, we also look at health and safety and well-being. Jane-ellen said she has a neighbor, for example, who has a cognitive impairment. He walks and as long as he stays on his route every day he doesn't get lost. He knows how to get home; so he would never get exception hours for wandering, because he is safe when he goes outside. It's only when he goes somewhere else in Salem that he can't find his way home, and gets lost, confused and distraught. Vanessa asked if we would count the number of times he goes to town and needs assistance. Jane-ellen said that is correct. Vanessa asked if we were being transparent about how many hours beyond the full assistance that are listed in the orders, or if that's a case-by-cases basis. Jane-ellen said it is a case-by-case basis because we are looking at the specific needs of the individual. So someone who has a cognitive impairment may only need supervision when they're awake and they never get up at night, etc. We would just be providing supports during that awake time period; whereas somebody else gets up in the middle of the night and wanders out into the community and is a danger to himself – he would need more hours. So it is all very, very specific. Someone with quadriplegia who needs a bowel routine may need a lot of hours in bowel care, but somebody else with the same condition doesn't have that need.

-For section (1)(c) (lines 20-33), we are looking at the reasons why an exception may be denied; they are listed here. Mat read (A)-(E) and asked there were any questions. Vanessa asked if music therapy is counted in the State Plan. Jane-ellen said it is not. Vanessa said she has heard of people being reimbursed for music therapy as an SLP therapy (speech and language therapy). Jane-ellen responded that any licensed therapies are not included in 1915k; they may be authorized under OHP if they are prescribed by the Doctor. Vanessa asked if this was based on funds. Jane-ellen said it was not; it is either the OHP/Oregon Health Authority's responsibility if the person is an "open card" or the Coordinated Care Organization's responsibility to make a determination if music therapy would be appropriate for the individual.

-Gordon wanted to highlight the preventive services language in here. The prevention definition you had earlier really is entirely circular with this since you are already saying that it is not something that falls into a particular ADL/IADL. He said he thinks that more globally, this is a concern that he comes across fairly frequently of, where does APD intend to draw the line

between preventative and non-preventative? And how real does a risk have to be that you are going to have a fall, or choke, or have some other need that is going to get you additional hours vs something that would be “just in case” care? Jane-ellen responded that what we are really trying to say here is that we don’t provide “just in case” care; but putting that in Rule seemed a little too relaxed. Gordon gets that; he is not saying that the phrase “just in case care” needs to be in Rule. Gordon said this is a very loose area. If he has a history of choking every time he has a meal, he would assume we would provide some additional support hours. But if he has a history of choking once in the last year, probably not; we’d say that was “just in case.” He asked where the line is, how likely the event has to be and how serious the harm has to be. Gordon thinks there is generally a lot of frustration on the part of consumers and their families when they come across these issues. And there are some real risks and some real concerns, and they get pushback from APD that we can’t provide preventative care, and that we can’t provide “just in case” care – which Gordon believes is reasonable – the Agency drawing the line somewhere. Gordon asked where exactly is that line? He stated that it is not really defined well anywhere in these rules. He doesn’t know if we (APD) have internally a sense of where that should be; he thinks maybe we do – and if so, he thinks it would be beneficial if we told him.

-Donitta asked if it would be part of the frequency rules: how often have they choked, how often have they needed help in the last 30 days. Jane-ellen said that to a certain degree that is where that is. But it has to meet the task, the frequency and the assistance types. We’ve discussed this in previous ADL committees where we talked about monitoring for choking, where people weren’t really doing anything. They were there just in case a person chokes. Everybody has the potential for choking vs a likelihood of choking. So we are not going to fund someone to stand there just in case you may choke some time, but that you have the likely need to do that. But it has to match the assistance types and the tasks that are defined in rule. And so maybe we stress that vs preventative service and we just say it doesn’t meet the assistance types. Donitta thinks they are not really well defined. Gordon thinks that can work for some ADLs. If you are saying we’re identifying you may have a risk for choking, so we will make sure somebody is there every time you have meals and give you some extra hours for that. But he thinks there are other tasks; for instance, if you have a risk of falls and you’ve had one serious fall in the last month – you meet something that classically would be in that 30-day look back, that’s a pretty serious event. Gordon said we’d all like to have somebody there for that but there is a known risk, it has

happened, it seems likely to happen again. But you are walking around 12 hours a day – he suspects APD would push back and agree the person has a pretty high risk of falling at some point in the next month, but APD doesn't want to pay for you having somebody there 12 hours a day, because we know you very likely will fall during that time period. Gordon asked where APD is drawing the line with it. Gordon said maybe he's wrong; maybe APD would say, "We know you've fallen in the last month. We know you are up and around walking 12 hours a day, we should fund you to have an attendant there 12 hours a day." Jane-ellen believes Gordon is right in the first analysis. We would probably define it more in the discussion that we had previously around frequency and duration. We wouldn't say, "You may have a potential for getting up and walking around somewhere in this 12-hour period." That is not what we will authorize. What we would say is, "How often are you getting up and how long is that taking," and then we authorize the hours for that particular frequency and duration of an approved task. Then the consumer, or their representative, has the responsibility for managing the service needs and the total hours authorized to meet those needs. So we wouldn't pay for 12 hours just in case they get up; what we would do is pay for, say, 'you're getting up six times a day, and it takes 15 minutes to do the task that you are doing (walking down the hall)' – so that's how we're calculating those exceptions. Gordon wouldn't say he is entirely agrees with that approach, but thinks that given APD's overall rhetoric of adding up time for particular tasks is consistent with how APD treats other things. He asked if APD would like to write this down in some way. Jane-ellen asked if he meant in the Rule. Gordon said it may not solve the problem but it is at least something a consumer could look at and say, "Alright. I have a risk of falling and APD will say 'we'll make sure that you have assistance for the amount of time you usually spend walking in a day. So we won't make sure somebody is there the whole time you are awake and out-and-about; but if you can have some way of regimenting your walking, we'll make sure that somebody is there to cover that likelihood.'" It is an example; obviously APD would have to create language that is much more generic than just the walking and falling scenario. Vanessa said that if the person could get up and fall at any time, that's what Gordon was covering, the 12 hours of awake time. Vanessa said if it could happen at any time, how would you calculate that. You need 15 minutes of assistance to walk around, but it could happen at any time. Gordon thinks it is a sort of fundamental breakdown of - where is APD going to draw the line. Gordon thinks it would be helpful to give those larger blocks of time that would

cover those really known risks and likelihoods. He understands that for some risks, that is a huge amount of time and funding that APD would have to come up with. But what he is hearing from Jane-ellen is a willingness to cover more than what he thought APD would, which is a positive first step. He thinks it's better to say we will cover the hour a day that we think you are walking around because you might fall during that hour. You figure out a way to make sure somebody is scheduled there all the times you are walking around. That's obviously not as good as saying... Mat said Gordon is talking about shift services. Gordon continued, "you are up and about potentially for a 12 hour period of time and we'll get somebody there 12 hours," but it's a start, and he'd at least like to see a start in Rule.

-Jane-ellen wants to be clear; we are not talking about authorizing "just in case". The 1915k does not conceive of, nor does APD's authorization conceive of, a "just in case" scenario. The consumer has the responsibility to manage their service plan. If consumer needs hands-on assistance with ambulation or transfers, then we are figuring out the amount of times that is happening during the day and the duration of that particular task, and then we are authorizing those particular hours (this is an exception case). So, the individual has fallen, but they are using a 4-wheel walker and they are able to get up and doing ok, then they could be totally independent in that example, even though they have fallen. Because, everybody can fall. It's falling and not able to get up, or to normally not be able to prevent yourself from falling. As an example, the individual cannot physically walk down the hall, or around their house, or out of their house without hands-on assistance, and they need to go out or around their home six times a day, we would say, "Six times a day. How long does that (in general) take you?" If the consumer says it takes them 15 minutes, we would multiply six times 15. Then if the consumer says they leave the home twice a week to go to the doctor or shopping (or whatever, going for a walk, or the Senior Center, or...) and that takes 20 minutes, we would multiply twice a week times 20. That is how we are calculating the hours. Then the consumer gets their block of hours that they have available and they are managing their service plan to those maximum hours. If this week they don't want to go to the Senior Center and they want them to person to help them around the house more, they can use the hours for that. If they want to go out more next week and they are saving some of their hours so they can go to the Senior Center and the doctor and (whatever) next week, it is our expectation that this is a consumer-directed program within the hours that we are authorizing. We're not providing "just in case"; and that includes, "You potentially may fall and

we are going to prevent you from falling” → That is NOT what we are doing. Jane-ellen directed us to look at page 29 (in (d)(A)-(E); lines 14-35), it explains that, where it is talking about how we determine the appropriate number of exception hours. We are looking at the frequency, the duration, the reasons, and the complexity. If you have someone with quadriplegia who is doing really well and doesn't need any additional assistance beyond getting into their chair and then they are good to go for the rest of the day vs someone who has quadriplegia, ventilator-dependency, and muscle spasms. We are looking at the complexity. Then we added (in (d)(G), lines 34-35), 'would denying the exception mean that they would have to go to an out-of-home placement, and would they have substantial unmet needs.' So we are defining that, and we take this rule language, and consumers are getting the misnamed brochure (right now it is really a Fact Sheet, but it's getting turned into a brochure) that explains the exceptions process. It talks about the concepts that we have defined in Rule, and turned that into a consumer-focused document.

-Donitta suggested that along with this (going back to the definition of preventative) we almost need to say something like, "it is something to prevent a need from occurring, such as..." Because we are not saying what we are preventing. Jane-ellen clarified that we were really just trying to say something besides "just in case" because we didn't want to put that phrase in Rule but we'll take a look at adding something else. Gwen said it is really getting back to the earlier conversation about the definition of preventative – which is, basically, is that it doesn't meet an ADL need, which is much broader. Donitta said it is to prevent something from happening. In her mind, preventative is taking medicine and going to the doctor. As Donitta now understands what we mean by "preventative", she (and Gwen) suggested, "to prevent services necessary for" or "a need not currently there." Jane-ellen wondered if we even need to take it out; maybe we say is...we turn (E) into, "For tasks not identified in 411-015" because it is the tasks: it's the ADLs and IADLs, it's the tasks within those ADLs and IADLs, and it the assistance types that matches those. Donitta said it would basically be something like monitoring when it is not an assistance type that is covered under (say) Ambulation. Jane-ellen thinks we need to define, in these rules, Assistance Types that reference back to the 411-015 rules. She suggested we remove "for preventative services" (OAR 411-030-0071(1)(c)(E), page 22, line 33) and remove the definition of "Preventative" (OAR 411-030-0020, new (42), page 7, lines 32-35). Then here we could say, "For tasks not covered in

“OAR 411-015-0006 and 411-015-0007 and assistance types.” The group liked this remedy and said it makes sense.

Suggested changes for Page 22:

- Line 12, add “specific” before “ADL” and before “IADL” to make the distinction clear between the exceptions for individual ADL and IA.
- Define Assistance Types that reference back to the 411-015 rules.
- Line 33, replace “preventative services” with “tasks not covered in OAR 411-015-0006 and 411-015-0007, and assistance types.”

***[Chris: Do we need to include “...and assistance types”? We use that verbiage in (1)(c)(C) on lines 27-28?]***

**Page 23**

We go into who has the responsibility (to request an exception) – and we made it clear that it can be in writing or orally. The CM can do this and the consumer needs to sign the application for it. Refer to the language we’ve included here (lines 1-15). Donitta recalled a CM who was having trouble with exception request because the location of the consumer; they were having trouble getting the consumer’s signature. Jane-ellen clarified that we are saying if the consumer requests (for example) 50 hours but the CM only thinks they need 25, we are reviewing the request for the 50 hours, not the request for 25 because the consumer gets to ask for what they think they need. And then we are defining that in-home care providers (lines 23-27) cannot ask for an exception but they can notify the CM that they have concerns that the service plan is not meeting the consumer’s needs. Mat emphasized that we really do want the CMs to help as much as possible – like in (c) and (d) (lines 11-21), even if they are given the ability to ask for exception hours. It can still be confusing to consumers, like, “What do I ask for? What can I ask for, or not ask for? What do I do?” The CMs are obligated to assist as much as possible to assist the consumer to request whatever they wish to request. Gwen asked what will happen if everyone thinks the consumer needs additional hours except the consumer doesn’t agree – rationally or irrationally – they don’t want (anyone) to apply. Jane-ellen responded that if they are cognitively capable and making their own decisions, they have the right to do that. We have consumers who turn down hours because of pay-in; they don’t take all of the hours that we can authorize for them because their pay-in takes too much of their income. Gwen asked that if they are not capable, they would just need a representative. Jane-ellen confirmed this is correct. Mat clarified that in (e) (lines 23-27), we wanted to make it abundantly clear that providers are not asking for an exception; it is the consumer or an appropriate representative

requesting the exception. Gwen shared that is where her thought came from; if a provider believes the person really needs more... Mat stated that we cannot permit a conflict of interest. Gwen said she is not arguing for that. Jane-ellen said she has seen it happen in a bad way, where the HCW or IHCA said the consumer needed more hours, and the way the CM was taking it was that they wanted more money; when really, that consumer had unmet needs. We are training on this. If the CM has a provider saying their consumer needs more hours, they need to take that seriously and review the case, not just blow it off. Mat said they can't assume it is about money, they need to go to the consumer and talk to them about it. Gwen said there is consistently an exception process, consistently needing more hours because of an emergency or whatever. Jane-ellen said this consumer was complex, they had developed wounds; it was bad.

-Regarding the exception application process, there is a new form. The consumer signs the form and... Donitta said she found the form and it almost seems too black and white. As mentioned earlier, Donitta has had CMs say they couldn't submit an exception request because they couldn't get the consumer's signature. Gwen asked what happens if someone cannot sign. Jane-ellen advised that their representative would need to sign, or they could do an "X" on it (for someone with, say, physical disabilities). We have processes in place. They have to proactively apply for Medicaid, so we have processes in place if they can't physically sign. If it is just geographic, it is still up to the CM to go out (or the case aide can) and get the signature. Or they can mail it and get it back.

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Again, this has been standard policy. The only thing that has really changed is the form has to be signed by the consumer and that they can start the process. We require that assessment has been done within three months because if there is something that is occurring that is a change of condition and there are hours that are needed, it means we need to do an assessment. But if it threatens the health and safety of the individual and we need to intervene immediately and get hours or providers into the home, then we need to move quickly to do that; so we have an exception to the Exception Process. We are saying that the Exception Application Form must clearly describe the need and is based on the frequency and the duration of the task, and the service needs that occur on a regular but unpredictable schedule. So there are things that happen that we'll want to accommodate. Individual needs catheter changing once a week that takes a long/extensive time. We want to accommodate that but we are not going to authorize

service hours for that every day for it. It should document those hours, or the time that is needed for those tasks.

### **Page 25**

The form has an attestation that all the information is accurate and truthful. The responsibility is on the consumer. This is a long-standing policy that when the Dept needs documentation, it is the consumer or representative's responsibility. But because the exception process is still a difficult process, we want to make sure that the CM is proactively working with the consumer to get the documentation and to help them get that documentation. About the documentation we are asking them for, there are some things that they have to provide and there are some things that we may ask them for. We have an exception calculator where you plug in the information and it gives us the amount of time we are going to authorize for each particular ADL or IADL. If the consumer has high needs and they're asking for many hours, we may ask for a time log to make sure that they are all Medicaid-funded services and supports, and any medical or mental health records that supports a specific exception request.

-Gwen thought they would be held by the provider typically, not the consumer. Jane-ellen said that HCW won't hold that information, but Gwen is correct for IHCA's. But sometimes it is a medical professional, like that exception where the consumer was spending nine hours of bowel care a day. Gwen said it would be the consumer that would request that the documentation be sent by the provider. Jane-ellen said that is more than likely. Donitta went back to the language in (3)(i) (lines 14-18). She asked if the expectation is that the CM is going to assist if it is needed, do we want to make that any stronger – in case a CM would be likely to say... Jane-ellen asked if we think a CM would ever say, "It says I may, but I'm not going to." Donitta said she may be cynical. Mat said he could see why she is bringing that up. Donitta suggested we say, 'it is your responsibility to do this.' Jane-ellen said we will change "may" to "shall" to make sure it doesn't ever happen. Gwen stated it's not purposeful, they're just overloaded. Donitta agreed; it is easy for them to say, "This is in your hands and it's up to you to do this." We will change it to "shall".

#### Suggested change for Page 25:

- Line 15, change "may" to "shall".

### **Page 26**

On the Decision-Making Authority for exceptions, Local Offices have the authority to make exception decisions up to these limits. This is based on current rule, so if we changed the hours in the Max hours, we would have to

change this, as well. And then if they go beyond that, they come to Central Office for review. Mat clarified that in (5)(a)(A) (line 6), where if ADL limit is 73 hours. If you were to add up all the Full Assist hours in ADL hours it equals 73. And IADLs (line 8), if you add up all the Full Assist hours it equals 35. So that's how we came up with those specific hours. In (5)(b) (lines 10-11), we are making it clear that Central Office has the final authority on hours if it is above that 73 limit or above that 35 limit that we previously looked at. Subsection (5)(d) (lines 22-25), part of the requirement if an exception is being reviewed is that the CM's Manager is responsible for getting the documentation and making sure everything is complete, accurate, justified – and they must make that decision (that everything looks good) within 14 days of when the consumer requested the exception. ***[Chris: What if they don't have all the requested documentation? (d) doesn't address that situation]***

-Donitta asked if (5)(d) should refer to (5)(a), not (5)(b). Mat said he misspoke. (5)(c) (lines 13-20) is meant for the Local Office review process. Donitta referred back to (5)(d) and said that while it references (5)(b) now, she really thinks it needs to reference (5)(a) – the local office. Because if it exceeds the Local Office's limits... not Central Office. Jane-ellen said Donitta is correct, it should be (5)(a).

-Gwen expressed concern about the potential length of time to approve an exception if you combine the Local Office review, determination that they can't really do it and then send it to Central Office; that could be as many as 45 days. Donitta said that is from the date of receipt of the application, which would be when it was first submitted by the consumer. Gwen said she read it as when they receive it from the Local Office. Jane-ellen clarified that in (5)(c), their 14 days is only if they are making a decision. Gwen said they are not, like if it takes them a while to realize they can't so they send it on. Then in (5)(e), DHS has no more than 30 days from date of receipt of the application. Jane-ellen explained that they are not cumulative. They will know from Day 1 if the exception request is over their max. They have 14 days to make a decision even if it's in their purview. If it's not within their purview, they send it to Central Office within three days. Gwen said they have two weeks to make a decision about whether they can make a decision (or not). They might make it Day 1, they might make it Day 14. They send it on to the Central Office who then has another 30 days. Donitta stated they would not send it to Central Office if it is something they would have made a decision on. Jane-ellen said it's the other way around; they are worried that the Local Office will sit on it for 14 days, then send it on. That is not the way

it is working because they know from the minute it is submitted if it is over their authority. Mat said they review it to make sure all the documentation is there (making sure it was filled out and that the documentation supports the request), but they aren't making a decision about whether it is enough to justify an exception. Donitta pointed to (5)(e) (line 28) where it says, "date of receipt", we should clarify 'the date of receipt from... the Local Office? From whom and to whom. Are you talking about when it was received from the consumer or when Central Office receives it from the Local Office? Gwen gave an example: Consumer sends it in. Local Office stamps it received 7/1. On 7/10, they send it to the Central Office because they realize they can't make a decision. Jane-ellen clarified that they have to do it within (5)(d) (lines 22-25), within three business days. Mat explained that (5)(c) (lines 13-20) is referring to what is in their purview; (5)(d) (lines 22-25) is when it is not in their purview. Gwen asked if the 30 days is after the date of receipt from the Local Office in (5)(d) – so it could be as long as 33 days. Jane-ellen clarified it is supposed be to the date it was received from the consumer. Gwen said that makes sense – date of receipt by the Local Office from the consumer; i.e., the original date of receipt. Mat stated it is 30 days from the start (when the consumer submits the request). Chris asked if it is 30 total days, or 33 days. Jane-ellen explained that the Local Office has to get it to us within three days, but the clock started back to the date of application - Day 1. Central Office may take 27 additional days. Donitta referred to "any supporting documentation" (line 29), which makes it sound like we can extend that 30 days. She asked why that comes into play under this 30-day timeframe. Jane-ellen responded that it has to be complete; the clock doesn't start until the application is complete. If the consumer verbally asks for an exception, and we say we need a HCW or IHCA time log and we don't have it, we can't make a decision. Mat stated that the clock hasn't started. Gwen believes this is a pretty long time, when you think about the realities of. If the Agency is providing services to this person who legitimately needs more hours (for example), and you are not going to deny them, so you do them and you find out 33 days later that you are not going to be paid. Donitta pointed to the 'exception to the exception' if there is an immediate need. Jane-ellen explained that, in general, we are trying to do them much faster than that. But since it is now in Administrative Rule, and it becomes an administrative error, and due process rights, that's why we are giving ourselves 30 days. Mat said we do not have an intention to wait that long. - Gwen asked if (5)(b) (line 10) says, "Only DHS Central Office shall make final decisions on exceptions exceeding the maximum hour limits," and in (5)(c),

“If the application meets the requirements... the Local Office can review the exception request and approve or deny.” That seems to contradict the statement right above it. Jane-ellen explained they are two levels of approval. One is if you meet the 108 hours or below – the Local Office fully gets to make a decision if the request for the exception is below 108 hours. If it goes above that, it has to come to Central Office. Gwen asked if somebody was approved for (say) 100 hours. The max is 108; so if the request was for 112 hours, the request would go to Central Office; but if the request was for 102 it would go to the Local Office. Jane-ellen confirmed that is correct.

Suggested changes for Page 26:

- Line 22, change “(5)(b)” to “(5)(a)”
- Lines 13-30, clarify the references to ‘date of receipt’ as “from the consumer” or “by the Local Office”; i.e., date of receipt by the Local Office from the consumer.

**Page 27**

The consumer can have 14 days to get information back. We’ve asked for, say, medical information, the time log, the exceptions calculator – any of that information – they have 14 days to get it back to us. And if they don’t get it back to us, we may make a decision, we may extend it, we may make a decision on the information we have, or we may fully deny it. The idea behind it is we do not want to have any exceptions sitting in Pending forever. When we are talking about the timeframes for getting us more information, the good cause language (in (h)(D) (line 27), (h)(E) (line 30), and (h)(F) line 34) here is consistent with other Medicaid good cause language, like asking for a hearing or initial application, etc.

**Page 28** No comments or questions.

This is what we are doing with each application. If it meets criteria and we think it’s appropriate, and the documentation supports the request, then we approve it. If we believe that it supports some of the hours but not everything, then we are going to grant those additional hours that we think are supported by the documentation. If it doesn’t support anything, we will give them a denial. If we do either a partial denial or a full denial, then the consumer gets a notice and has hearing rights applicable to that partial or full denial. Big (6) (line 18) is explaining how we are reviewing it and what we are looking at: assessment comments, treatments, diagnosis...(turn to page 29)

**Page 29** No comments or questions.

...medical documentation, the reasons driving the increased duration, and any other information that is provided. We touched on this earlier, but we

are determining the appropriate number of exception hours based on frequency, duration, the reasons, the number of individuals necessary to perform an assessed task (e.g., the person needs two-person transfers; we are going to give additional hours for two people), and whether denying the exception will put the consumer at risk of out-of-home placement, or would result in a substantial unmet need of the individual. We can reduce the requested hours if the consumer's needs are being met by...(turn to page 30)

**Page 30** No comments or questions.

...the availability of natural supports, durable medical equipment, assistive devices or technology, emergency response systems, home-delivered meals, other supports that replace the need for human assistance as determined on a case-by-case basis (e.g., we have one home where we have two younger people with quadriplegia and there are Hoyer lifts in the ceiling and track systems that they are to be very independent throughout the day, so they don't get as many hours as most people with quadriplegia), the requested hours that do not meet ALD and IADL definitions, or the way the tasks are being performed where it's not medically appropriate as determined by a medical professional. We're not making that determination; but if a medical professional is saying this should take ½ an hour and this is the way to do it, we're going to go with that. Or if the individual wants a homeopathic remedy or something they've come up with but it's not medically appropriate based on the LTC nurse, or the medical professionals, then we are not going to authorize hours for that task in that manner. Then (7) (line 30) talks about notification – so they will get a notice. It's a normal notice, so it will have all the documentation...(turn to page 31)

**Page 31**

...Generally, exceptions are approved for a year, but not always. So if it because of a medical condition it may be shortened. If we are trying it to see if this is going to work, if we need to go up or down, those things are going to be defined in the notice. Any exception expires at the end date, and for consumers that are being reassessed, we will already be starting the exceptions process so there is no gap in the exception. We went through this rather quickly, but it is basically the process we are using now.

Vanessa asked if there are any exception hours granted for overlapping care for training prior HCWs to be training new HCWs. Jane-ellen responded that it is not an approved activity. Vanessa asked how we expect the new person to get trained. Jane-ellen explained that the consumer can use their service hours in the manner that they want to do that. So if they have someone who is a new care provider, they can use the hours they are authorized to have

that care provider come in and learn how to provide the care in an appropriate way, or they can use the LTC Community Nursing System to provide teaching and delegation to that HCW on the hours that are currently authorized for that HCW. Vanessa said that basically the HCW goes unpaid or paid; and then the trainer goes paid or unpaid. Vanessa asked if we are saying only one person can be paid at a time. Jane-ellen corrected her; that is not what we are saying. The consumer, or their representative, gets to manage the hours. If they decide they want HCW A train HCW B, then they are paying both HCWs at the same time from the authorized hours that are already available. Vanessa stated that is not clear to CMs; it was requested and... Vanessa was not sure how to talk about this without talking about... Jane-ellen explained it is not an exception; it's using the authorized hours that are already available in the service plan that are authorized to each HCW. Vanessa said the CM said that was reasonable, then checked with her supervisor and they denied it. She thinks there is a miscommunication in the system about that. Jane-ellen said she didn't know why that happened, but stated that they can discuss this offline. Jane-ellen suspects the CM is confused about some of this. Mat and Jane-ellen will follow up with Vanessa in the next few days.

-On the bottom of the page is the Exceptions to HCW Cap (lines 30-39). This was mixed up in the previous rule altogether. We wanted to make it clear there is a separate process (it is the same process), a separate determination. A consumer may be getting an exception to the hours, and getting more hours. And then we may also be reviewing if it is appropriate for the HCW to have an exception to the cap because each HCW is either authorized to work 40 hours or 50 hours. The only reason we make exceptions to those caps is based on the service needs of the individual, and not the request or the desire of the HCW. So that is what is defined on the bottom of page 31... (turn to page 32)

**Page 32**

...and at the bottom of page 32, (5) (lines 27-40), explains why we would approve exceptions to the HCW cap. And that goes onto page 33.

**Page 33**

This is hearable and the consumer will get notice about it. Mat as if there were any questions about why we would grant an exception to the HCW cap. Gwen said the only question she was going to ask for herself was how it relates to the top of page 20, 'can't work more than 50 hours in some and 40 in others'. She asked if that was only for in-home care agencies or HCWs. Jane-ellen explained the cap is only for HCWs.

**Overall Comments, Concerns, Questions, Feedback or Other Input**

Vanessa asked for clarification: If we have three HCWs besides herself, and they can't cover the hours, can she raise her cap just for that time, to cover? Jane-ellen said in the example, everybody has a 40-hour cap but somebody can't work a particular week (for whatever reason) and there is still 10 hours in the consumer's service plan; can you do a temporary exception to the cap. Vanessa confirmed this is her question – temporary to the cap, a release. Jane-ellen said sometimes; it has to be prior authorized and in complicated service plans they will often allow an exception to the cap so there is some kind of backup in case one of the other primary HCWs can't make it. So there is a potential for that. It has to be prior authorized in particular cases; it's not always guaranteed, but we can look at each case. Vanessa restated that the caps can be increased in case of emergency or availability temporarily. Mat stated, yes, temporarily. But to clarify, the cap is the cap, so we are not doing permanent changes to one's cap. We just want to make that clear. Vanessa said it is very clear and that some are on vacation, one got injured, and it's one person left. Mat said we can do temporary exceptions to the HCW cap and we definitely; but as Jane-ellen said, they have to be prior authorized unless there is an emergency issue. We obviously don't want to put the consumer at risk. And the provider may work as long as it is within those two business days. But other than that circumstance, there is a prior authorization that needs to occur though *before* working it. Vanessa asked if it occurs verbally, then get a call that says, "unapproved" and the HCW has already done that based on a verbal with CM, for example? Jane-ellen stated those situations do occur where there was verbal authorization and then somehow it didn't make it onto the paper. We've resolved those issues on a routine basis. CMs are not supposed to be giving verbal authorization, but they often do, especially late in the day or in emergency situations, but we will work out the cases on a case-by-case basis. Donitta asked if only Central Office that can make that decision, or if Local Offices can make those decisions. Mat clarified that for (5) (page 32, lines 27-40; page 33, lines 1-12) it is Central Office only.

Wrap-up

- We will make discussed changes and review the other recommendations.
- We will then send an electronic copy to everyone here; you will have five (5) business days to respond and provide any additional feedback.
- Then these rules will be made permanent.