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

CHAPTER 411
DIVISION 30

IN-HOME SERVICES

411-030-0001 *(Renumbered 6/1/1993 to OAR 411-030-0040)*

411-030-0002 Purpose and Scope
(Amended 11/1/2013)

(1) The rules in OAR chapter 411, division 030 ensure that in-home services maximize independence, empowerment, dignity, and human potential through the provision of flexible, efficient, and suitable services. In-home services fill the role of complementing and supplementing an individual's own personal abilities to continue to live in his or her own home or the home of a relative.

(2) Medicaid in-home services are provided through the Consumer-Employed Provider Program, Spousal Pay Program, Independent Choices Program, and other approved service providers.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.070

411-030-0020 Definitions
(Temporary Effective 05/23/18 to 11/18/18)

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

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

(2) "APD" means the Aging and People with Disabilities program within the Department of Human Services.

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

(4) "Area Agency on Aging (AAA)" means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to individuals in a planning and service area. The term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300.

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

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

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

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

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

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

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

(a) Is a single data system used for:

(A) Completing a comprehensive and holistic assessment;

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

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

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

(12) "Consumer" or "Consumer-Employer" means an individual eligible for in-home services.

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

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

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

(16) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly

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

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

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

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

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

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

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

(23) "Exception" means the following:

(a) An approval for payment of a service plan granted to a specific individual in their current residence or in the proposed residence identified in the exception request that exceeds the CA/PS assessed service payment levels for individuals residing in community-based care facilities or the maximum hours of service as described in OAR 411-030-0071 for individuals residing in their own homes or the home of a relative.

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

(c) An approval of a service plan granted to a specific individual and a homecare worker to exceed the limitations as described in OAR 411-030-0070(5) based upon the service needs of the individual as determined by the Department.

(d) Additional hours provided to an individual who meets the criteria for shift services, as described in OAR 411-030-0068, that exceed the 16 hours of service per day.

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

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

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

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

(a) The term homecare worker includes:

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

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

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

(b) The term homecare worker does not include an Independent Choices Program provider or a personal support worker enrolled through Developmental Disability Services or the Addictions and Mental Health Division.

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

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

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

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

(32) "Individual" means a person age 65 or older, or an adult with a physical disability, applying for or eligible for services.

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

(34) "In-Home Services" mean those services that meet an individual’s assessed need related to activities of daily living and instrumental activities of daily living while the individual is living in their own home or in the home of a relative.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 409.050, 410.070, 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070

411-030-0033 In-Home Service Living Arrangements
(Amended 12/28/2016)

(1) The following terms are used in this rule:

(a) "Informal arrangement" means a paid or unpaid arrangement for shelter or utility costs that does not include the elements of a property manager's rental agreement.

(b) "Property manager's rental agreement" means a payment arrangement for shelter or utility costs with a property owner, property manager, or landlord that includes all of the following elements:

(A) The name and contact information for the property manager, landlord, or leaser.

(B) The period or term of the agreement and method for terminating the agreement.

(C) The number of tenants or occupants.

(D) The rental fee and any other charges (such as security deposits).

(E) The frequency of payments (such as monthly).

(F) What costs are covered by the amount of rent charged (such as shelter, utilities, or other expenses).

(G) The duties and responsibilities of the property manager and the tenant, such as:

(i) The person responsible for maintenance;

(ii) If the property is furnished or unfurnished; and

(iii) Advance notice requirements prior to an increase in rent.

(c) "Provider-owned dwelling" means a dwelling that is owned by a provider or the provider's spouse, when the provider is proposing to be paid for providing Medicaid home and community-based services, and the provider or the provider's spouse is not related to an individual by blood, marriage, or adoption. Provider-owned dwellings include, but are not limited to:

(A) Houses, apartments, and condominiums.

(B) A portion of a house such as basement or a garage even when remodeled to be used as a separate dwelling.

(C) Trailers and mobile homes.

(D) Duplexes, unless the structure displays a separate address from the other residential unit and was originally built as a duplex.

(d) "Provider-rented dwelling" means a dwelling that is rented or leased by a provider or the provider's spouse, when the provider is proposing to be paid for providing Medicaid home and community-based services, and the provider or the provider's spouse is not related to an individual by blood, marriage, or adoption.

(2) An individual is eligible for Medicaid in-home services if the individual resides in a --

(a) Dwelling the individual owns or rents;

(b) Provider-owned dwelling and the individual's name is on the property deed, mortgage, or title;

(c) Provider-rented dwelling and the individual's name is on the property manager's rental agreement;

(d) Dwelling, either through an informal arrangement or property manager's rental agreement, owned or rented by a relative as defined in OAR 411-030-0020.

(3) An individual is not eligible for Medicaid in-home services if the individual resides in a provider-owned or rented dwelling through an informal or formal arrangement. A provider-owned or rented dwelling may meet the requirements for a limited adult foster home as described in OAR 411-050-0605.

Stat. Auth.: ORS 409.050, 410.070, 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070

411-030-0040 Eligibility Criteria
(Temporary Effective 05/23/18 to 11/18/18)

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

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

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

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

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

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

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

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

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

(d) Be 18 years of age or older.

(4) EMPLOYER RESPONSIBILITIES.

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

(A) Locate, screen, and hire a qualified homecare worker;

(B) Supervise and train the homecare worker;

(C) Schedule the homecare worker's work, leave, and coverage;

(D) Track the hours worked and verify the authorized hours completed by the homecare worker;

(E) Recognize, discuss, and attempt to correct any performance deficiencies with the homecare worker;

(F) Discharge an unsatisfactory homecare worker; and

(G) Follow all employer responsibilities required by law to ensure the workplace is safe from harassment.

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

(A) Individuals who have failed to meet the responsibilities in subsection (a) of this section and who does not have a

representative are ineligible for in-home services provided by a homecare worker.

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

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

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

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

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

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

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

(5) REPRESENTATIVE.

(a) The Department may require that an individual obtain a representative.

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

(c) An individual with a guardian must have a representative for service planning purposes. A guardian may designate themselves as the representative.

(d) A representative may not be a paid caregiver.

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

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

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

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

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

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

(b) A nursing facility;

(c) Prison;

(d) A hospital; or

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

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

Stat. Auth.: ORS 409.050, 410.070, 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070

411-030-0050 Case Management
(Amended 1/28/2018)

(1) ASSESSMENT. The assessment process identifies an individual's ability to perform ADLs, IADLs, and determines an individual's ability to address health and safety concerns.

(a) The case manager must conduct an assessment in accordance with the standards of practices established by the Department in OAR 411-015-0008.

(b) The assessment must be conducted by a case manager or other qualified Department or AAA representative with a standardized assessment tool approved by the Department in the home of the eligible individual, no less than annually.

(2) PERSON-CENTERED SERVICE PLAN.

(a) An individual receiving services, or the individual’s representative and the individual's case manager, must consider in-home service options as well as assistive devices, architectural modifications, and other community-based resources to meet the service needs identified in the assessment process.

(A) The individual or the individual's representative is responsible for choosing and assisting in developing less costly service alternatives, including the Consumer-Employed Provider Program and contracted in-home care agency services.

(B) The case manager is responsible for --

(i) Determining eligibility for specific services;

(ii) Presenting service options, resources, and alternatives to the individual to assist the individual in making informed choices and decisions;

(iii) Identifying risks;

(iv) Assisting the individual with developing backup plans;

(v) Identifying the individual’s goals and preferences;

(vi) Assessing the cost effectiveness of the individual's service plan; and

(vii) Developing and coordinating a person-centered service plan.

(C) The case manager must monitor the service plan and make adjustments as needed.

(b) The Department takes necessary safeguards to protect an individual's health, safety, and welfare in implementing an individual's service plan in accordance with 42 CFR 441.302 and 42 CFR 441.570. When an individual with the ability to make an informed decision selects a service choice that jeopardizes health and safety, the Department or AAA staff shall offer or recommend options to the individual in order to minimize those risks. For the purpose of this rule, an "informed decision" means the individual understands the benefits, risks, and consequences of the service choice selected. Options that minimize risks may include offering or recommending:

(A) Natural supports to provide assistance with safety or health emergencies;

(B) An emergency response system;

(C) A back-up plan for assistance with service needs;

(D) Resources for emergency disaster planning;

(E) A referral for long term care community nursing services;

(F) Resources for provider and consumer training;

(G) Assistive devices; or

(H) Architectural modifications.

(c) The Department or AAA may not authorize a service provider, service setting, or a combination of services selected by an eligible individual or the individual's representative when --

(A) The service setting has dangerous conditions that jeopardize the health or safety of the individual and necessary safeguards cannot be taken to improve the setting;

(B) Services cannot be provided safely or adequately by the service provider based on --

(i) The extent of the individual's service needs; or

(ii) The choices or preferences of the eligible individual or the individual's representative;

(C) Dangerous conditions in the service setting jeopardize the health or safety of the service provider that is authorized and paid for by the Department, and necessary safeguards cannot be taken to minimize the dangers; or

(D) The individual does not have the ability to make an informed decision, does not have a designated representative to make decisions on his or her behalf, and the Department or AAA cannot take necessary safeguards to protect the safety, health, and welfare of the individual.

(d) The case manager must present the individual or the individual's representative with information on service alternatives and provide

assistance to assess other choices when the service provider or service setting selected by the individual or the individual's representative is not authorized.

(3) PAYMENT.

(a) The service plan payment is considered full payment for Medicaid home and community-based services rendered. Under no circumstances is the service provider to demand or receive additional payment for these services from the consumer or any other source.

(b) Additional payment to homecare workers or ICP employee providers for the same services covered by Medicaid in-home services or the Spousal Pay Program is prohibited.

(c) For ICP, the service plan must include the service budget as described in OAR 411-030-0100.

(d) For service plans in which a consumer lives in the relative homecare workers home, subsection (a) of this section does not apply to rent and living expenses.

Stat. Auth.: ORS 409.050, 410.070, 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070

411-030-0055 Community Transportation
(Amended 1/28/2018)

(1) Community transportation (non-medical) may be prior-authorized for reasons related to an eligible individual's safety or health, in accordance with the individual's service plan. Community transportation is offered through contracted transportation providers or by homecare workers.

(2) Community transportation may be authorized to assist an eligible individual in getting to and from the individual's place of employment when the individual is approved for the Employed Persons with Disabilities Program (OSIPM-EPD).

(3) Natural supports, volunteer transportation, and other transportation services available to an eligible individual are considered a prior resource and may not be replaced with transportation paid for by the Department.

(4) Health Systems Division is a resource for medical transportation to a physician, hospital, clinic, or other medical service provider. Medical transportation costs are not reimbursed through community transportation.

(5) Community transportation is not provided by the Department to obtain medical or non-medical items that may be delivered by a supplier or sent by mail order without cost to the eligible individual.

(6) Community transportation must be prior authorized by an individual's case manager and documented in the individual's service plan. The Department does not pay any provider under any circumstances for more than the total number of hours, miles, or rides prior authorized by the Department or AAA and documented in the individual's service plan.

(a) Contracted transportation providers are reimbursed according to the terms of their contract with the Department. Community transportation services provided through contracted transportation providers must be authorized by a case manager based on an estimate of a total count of one way rides per month.

(b) Homecare workers who use their own personal vehicle for community transportation are reimbursed according to the terms defined in their Collective Bargaining Agreement between the Home Care Commission and Service Employees International Union, Local 503, OPEU. Any mileage reimbursement authorized to a homecare worker must be based on an estimate of the maximum miles required to drive to and from the destination authorized in an individual's service plan. Community transportation hours are authorized in accordance with OAR 411-030-0070.

(c) The Department or AAA does not authorize reimbursement for travel to or from the residence of a homecare worker. The Department or AAA only authorizes community transportation and mileage from the home of an eligible individual to the destination authorized in the individual's service plan and back to the individual's home.

(7) The Department is not responsible for any vehicle damage or personal injury sustained while using a personal motor vehicle for community transportation.

Stat. Auth.: ORS 409.050, 410.070, 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070

411-030-0068 Shift Services
(Amended 1/28/2018)

(1) An individual is only eligible for shift services if the assessment determines the individual meets the criteria described in section (2) of this rule.

(2) Individuals with service plans that meet the definition of shift services must meet subsections (a) and either (b) or (c) of this section of the rule.

(a) The provision of assistance with at least one ADL or IADL task must be required sometime during each hour the individual is awake in order to ensure the safety and well-being of the individual.

(b) The individual is assessed as full assist in mobility or elimination as defined in OAR 411-015-0006, and has at least one of the following conditions:

(A) A debilitating medical condition that includes, but is not limited to, any of the following:

(i) Cachexia;

(ii) Severe neuropathy;

(iii) Coma;

(iv) Persistent or reoccurring stage 3 or 4 wounds;

(v) Late stage cancer;

(vi) Frequent and unpredictable seizures; or

(vii) Debilitating muscle spasms.

(B) A spinal cord injury or similar disability with permanent impairment.

(C) An acute care or hospice need that is expected to last no more than six months.

(c) The individual is assessed as full assist in cognition as defined in OAR 411-015-0006.

(3) An individual may employ homecare workers with a differential rate in accordance with the terms of the ratified collective bargaining agreement described in OAR 411-031-0020, if the following applies:

(a) The individual is diagnosed with quadriplegia or a condition that is substantially similar;

(b) The individual is dependent on a ventilator;

(c) The individual is eligible for and receives shift services;

(d) The individual requires 24-hour awake care, of which, at least 16 hours must be paid shift care; and

(e) The plan is approved by Central Office.

Stat. Auth.: ORS 409.050, 410.070, 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070

411-030-0070 Maximum Hours of Service
(Temporary Effective 05/23/18 to 11/18/18)

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

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

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

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

(2) MAXIMUM SERVICE PERIOD HOURS FOR ADL.

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

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

(A) Eating:

(i) Minimal assistance, three hours.

(ii) Substantial assistance, nine hours.

(iii) Full assistance, fourteen hours.

(B) Dressing and Grooming:

(i) Minimal assistance, two hours.

(ii) Substantial assistance, seven hours.

(iii) Full assistance, nine hours.

(C) Bathing and Personal Hygiene:

(i) Minimal assistance, five hours.

(ii) Substantial assistance, seven hours.

(iii) Full assistance, twelve hours.

(D) Mobility:

(i) Minimal assistance, five hours.

(ii) Substantial assistance, seven hours.

(iii) Full assistance, twelve hours.

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

(i) Minimal assistance, five hours.

(ii) Substantial assistance, nine hours.

(iii) Full assistance, fourteen hours.

(F) Cognition:

(i) Minimal assistance, three hours.

(ii) Substantial assistance, six hours.

(iii) Full assistance, twelve hours.

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

(d) The Case Manager may authorize fewer hours than the maximum number of hours in any or all ADL tasks based on their assessment of the individual's unmet need. The Case Manager must document the reason for authorizing fewer hours than the maximum number of hours allowed. The case manager may authorize fewer hours than the maximum for one of the following defined reasons:

(A) Reduced frequency or duration.

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

(C) Individual preference.

(D) Natural supports.

(E) Provided or funded by another agency.

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

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

(3) MAXIMUM SERVICE PERIOD HOURS FOR IADL.

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

(A) Medication Management:

(i) Minimal assistance, one hour.

(ii) Substantial assistance, two hours.

(iii) Full assistance, five hours.

(B) Transportation:

(i) Minimal assistance, one hour.

(ii) Substantial assistance, one hour.

(iii) Full assistance, two hours.

(C) Meal Preparation:

(i) Minimal assistance:

(I) Breakfast, one hour.

(II) Lunch, one hour.

(III) Supper, two hours.

(ii) Substantial assistance:

(I) Breakfast, two hours.

(II) Lunch, two hours.

(III) Supper, three hours.

(iii) Full assistance:

(I) Breakfast, five hours.

(II) Lunch, five hours.

(III) Supper, six hours.

(D) Shopping:

(i) Minimal assistance, one hour.

(ii) Substantial assistance, two hours.

(iii) Full assistance, three hours.

(E) Housekeeping and Laundry:

(i) Minimal assistance, two hours.

(ii) Substantial assistance, five hours.

(iii) Full assistance, nine hours.

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

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

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

(e) The Case Manager may authorize fewer hours than the maximum number hours in any or all IADLs based on their assessment of the individual's unmet need. The Case Manager must document the reason for authorizing fewer hours than the maximum hours. The Case Manager may reduce hours for one of the following reasons:

(A) Reduced frequency or duration.

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

(C) Individual preference.

(D) Natural supports.

(E) Provided by or funded by another agency.

(F) Small living space.

(4) When one or more eligible individuals are living in the same household and receiving in-home services, the number of hours authorized for ADLs and IADLs may not exceed 24 hours within any 24-hour period in the same household.

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

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

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

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

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

(7) A homecare worker may be authorized by the Department to work more than 16 hours of hourly services during a 24-hour work period if an unanticipated need arises that requires the homecare worker to remain awake to provide necessary care.

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

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

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

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

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

Stat. Auth.: ORS 409.050, 410.070, 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070

411-030-0071 Exceptions to Maximum Hours of Service
(Temporary Effective 05/23/18 to 11/18/18)

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

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

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

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

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

(B) Not medically appropriate.

(C) For assistance types not allowed by rule for a particular ADL or IADL.

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

(E) For preventative services.

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

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

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

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

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

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

(3) Exception Application Process.

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

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

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

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

(c) After discussing alternatives ways to meet the consumer’s needs described in subsection (b) of this rule, if the consumer continues to desire an exception, then the exception application shall be processed.

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

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

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

(g) The Exception Application Form must clearly describe:

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

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

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

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

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

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

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

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

(4) Required Documentation.

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

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

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

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

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

(5) Exception Decision Making Authority.

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

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

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

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

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

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

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

(f) In emergency situations that threaten the health, welfare or safety of the individual, DHS CO will make a decision within two business days of receipt of the application.

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

(h) The consumer or their representative, or the case manager must provide the requested information to DHS CO within 14 days of the Department’s request. The request for additional information shall

specify the due date and explain how to submit the required information.

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

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

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

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

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

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

(i) For each Exception Application:

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

(B) If the Department determines the documentation supports additional hours, but not as many hours as requested or for the

timeframe requested, the exception will be granted for only those additional hours supported by the documentation.

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

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

(6) Exception Application Reviews and Decision Making.

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

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

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

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

(B) Treatments that may drive care needs;

(C) Diagnosis that may drive care needs;

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

(E) Medical documentation, including those from the Long-Term Care Community Nurse or Behavior Support Specialists, that

shows that the current level of services is not meeting the consumer's needs;

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Emergency Response Systems;

(D) Home and Environmental Modifications;

(E) Home Delivered Meals;

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

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

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

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

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

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

(7) Notification.

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

(b) Notification shall include:

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

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

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

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

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

(F) The duration of the exception.

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

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

(9) Reassessments.

(a) If a consumer has an existing exception, the exception shall be reviewed prior to the exception end date.

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

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 410.070

411-030-0072 Exceptions to the Homecare Worker Cap
(Temporary Effective 05/23/18 to 11/18/18)

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

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

(3) Exception to Homecare Worker Cap Application Process.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 410.070

411-030-0080 Spousal Pay Program
(Amended 1/28/2018)

(1) The Spousal Pay Program is one of the hourly service options under in-home services for those who qualify.

(2) ELIGIBILITY. An individual may be eligible for the Spousal Pay Program when all of the following conditions are met:

(a) The individual has met all eligibility requirements for in-home services as described in OAR 411-030-0040.

(b) The individual requires full assistance in at least four of the six ADLs described in OAR 411-015-0006 as determined by the assessment described in OAR chapter 411, division 015.

(c) A debilitating medical condition including, but is not limited to, any of the following:

(A) Cachexia;

(B) Severe neuropathy;

(C) Coma;

(D) Persistent or reoccurring stage three or four wounds;

(E) Late stage cancer;

(F) Frequent and unpredictable seizures;

(G) Debilitating muscle spasms; or

(H) A spinal cord injury or similar disability with permanent impairment.

(d) The individual would otherwise require nursing facility services without Medicaid in-home services.

(e)The individual’s service needs exceed in both extent and duration the usual and customary services rendered by one spouse to another.

(f) The spouse demonstrates the capability and health to provide the services and actually provides the principal services, including the majority of service plan hours, for which payment has been authorized.

(g) The spouse meets all requirements for enrollment as a homecare worker in the Consumer-Employed Provider Program as described in OAR 411-031-0040.

(h) The spouse is not designated as a representative as described in OAR 411-030-0040.

(i) The Department has reviewed the request and approved program eligibility at enrollment and annually upon re-assessment.

(3) PAYMENTS.

(a) All payments must be prior authorized by the Department or the Department's designee.

(b) The hours authorized to the spousal pay provider in an individual's service plan must consist of one-half of the assessed hours for IADLs and all of the hours for specific ADLs based on the service needs of the individual.

(c) Except as described otherwise in subsection (d) of this section, spousal pay providers are paid at hourly homecare worker rates for ADLs and IADLs as defined in the rate schedule.

(d) Homecare workers who marry their consumer-employer are not paid under the spousal pay program. Service plans are based on the needs of the consumer. Hours assigned must reflect the service needs with no reduction in hours. The consumer does not need to meet the spousal pay eligibility criteria as described in section (3) of this rule. Hours authorized in CA/PS will be completed in the same manner as other in-home service plans, which include hourly or Independent Choices Program.

(e) Spousal pay providers may not claim payment from the Department for hours that the spousal pay provider did not work.

(f) A spousal pay HCW may not act as the consumer-employer.

(4) Spousal pay providers are subject to the provisions in OAR chapter 411, division 031 governing homecare workers enrolled in the Consumer-Employed Provider Program.

(5) Individuals receiving Spousal Pay Program services who have excess income must contribute to the cost of services pursuant to OAR 461-160-0610 and OAR 461-160-0620.

Stat. Auth.: ORS 409.050, 410.070, 410.090
Stats. Implemented: ORS 410.010, 410.020, 410.070, 411.802, 411.803

411-030-0090 Contracted In-Home Care Agency Services
(Renumbered to 411-033-0020 05/30/2017)

411-030-0100 Independent Choices Program
(Amended 1/28/2018)

(1) The Independent Choices Program (ICP) is an In-Home Services Program that empowers participants to self-direct their own service plans and purchase goods and services that enhance independence, dignity, choice, and well-being.

(2) The Department may not change the ICP participation agreement without posting the changes for public notice on the Department's website.

(3) The ICP is limited to a maximum of 2,600 participants.

(a) The Department establishes and maintains a waiting list for individuals eligible for in-home services requesting ICP after the ICP has reached its maximum.

(b) The Department enters eligible individuals' names on the waiting list according to the date the individual applied for participation in ICP.

(c) As vacancies occur, eligible individuals on the waiting list are offered the ICP according to his or her place on the waiting list.

(d) Individuals on the waiting list may receive services through other appropriate Department programs they are eligible.

(4) INITIAL ELIGIBILITY REQUIREMENTS.

(a) To be eligible for the ICP an individual must:

(A) Meet all requirements for in-home services as described in these rules.

(B) Develop a service plan and budget to meet the needs identified in his or her CA/PS assessment.

(C) Sign the ICP participation agreement.

(D) Have or be able to establish a checking account.

(E) Provide evidence of a stable living situation for the past three months.

(F) Demonstrate the ability to manage money as evidenced by timely and current utility and housing payments.

(G) Demonstrate the ability to manage and honor the employee provider responsibilities as outlined in the ICP participation agreement.

(b) If a participant is unable to direct and purchase their own in-home services, the participant must have a representative to act on the participant's behalf. The "representative" is the person assigned by the participant to act as the participant's decision maker in matters pertaining to the ICP service plan and service budget. A representative must:

(A) Complete a background check pursuant to OAR chapter 407, division 007 and receive a final fitness determination of approval; and

(B) Sign and adhere to the "Independent Choices Program Representative Agreement" on behalf of the participant.

(c) If a participant is unable to manage the ICP cash payment accounting, tax, or payroll responsibilities and does not have a representative, the participant must arrange and purchase the ongoing services of a fiscal intermediary, such as an accountant, bookkeeper, or equivalent financial services.

(A) A participant, or the participant's representative who has met the eligibility criteria in subsection (b) of this section, may also choose to use a fiscal intermediary.

(B) The participant is responsible for any fees or payment to the fiscal intermediary and may allocate the fees or payment from discretionary or other non-ICP funds.

(5) DISENROLLMENT CRITERIA. Participants may be disenrolled from the ICP voluntarily or involuntarily. Participants who are disenrolled from the ICP may not reapply for six months. After the six month disenrollment period, an individual may re-enroll and must meet all ICP eligibility requirements. If the ICP enrollment cap has been reached, participants who were disenrolled are added to the waiting list.

(a) VOLUNTARY DISENROLLMENT. Participants or representatives must provide notice to the Department of intent to discontinue participation in the ICP. The participant or the representative must meet with the Department to reconcile remaining ICP cash payment either within 30 days of the date of disenrollment or before the termination date, whichever is sooner.

(b) INVOLUNTARY DISENROLLMENT. The participant may be involuntarily disenrolled from the ICP when the participant, representative, or employee provider does not adequately meet the participant's service needs or carry out any of the following ICP responsibilities:

(A) Non-payment of employee’s wages, as stated in the service budget.

(B) Failure to maintain the participant's health and well-being by obtaining personal care as evidenced by:

(i) Decline in functional status due to the failure to meet the participant’s needs; or

(ii) Substantiated complaints of self-neglect, neglect, or other abuse on the part of the employee provider or representative.

(C) Failure to purchase goods and services according to the participant's service plan.

(D) Failure to comply with the legal or financial obligations as an employer.

(E) Failure to maintain a separate ICP checking account or commingling ICP cash benefit with other assets.

(F) Inability to manage the cash benefit as evidenced by two or more incidents of overdrafts of the participant's ICP checking account during the last cash benefit review period.

(G) Failure to deposit monthly service liability payment into the ICP checking account.

(H) Failure to maintain an individualized back-up plan (as part of the participant's service plan) resulting in a negative consequence.

(I) Failure to sign or follow the ICP Participation Agreement.

(J) Failure to designate a representative within 30 days if a participant needs a representative, as determined by the Department, and does not have one.

(K) Failure to abide by state and federal labor laws.

(6) INTERRUPTION OF SERVICES. The ICP cash benefit is terminated when a participant is absent from the home for longer than 30 days due to illness or medical treatment. The cash benefit may resume upon the participant's return to the home, providing ICP eligibility criteria is met.

(7) SELECTION OF EMPLOYEE PROVIDERS.

(a) The participant or representative carries full responsibility for locating, screening, interviewing, hiring, training, paying, and terminating employee providers. The participant or representative

must comply with Immigration and Customs Enforcement laws and policies.

(b) The participant or representative must assure the employee provider's ability to perform or assist with ADL and IADL service needs.

(c) Employee providers must complete a background check pursuant to OAR chapter 407, division 007. If a record of a potentially disqualifying crime is revealed, the participant or representative may employ the provider at the participant's or representative's discretion.

(d) A representative may not be an employee provider regardless of relationship to the participant.

(e) A participant's relative may be employed as an employee provider.

(8) CASH BENEFIT.

(a) The cash benefit is determined based on the participant's CA/PS assessment of need, service plan, level of assistance standards in OAR 411-030-0070, and natural supports.

(b) The cash benefit is calculated by adding the ADL task hours and the IADL task hours that the participant is eligible for as determined in the CA/PS assessment, at the rates according to the Department's rate schedule.

(c) The following services, which are approved by the case manager and paid for by the Department, are excluded from the ICP cash benefit:

(A) Long-term care community nursing.

(B) Contracted community transportation.

(C) Medicaid home delivered meals.

(D) Emergency response systems.

(d) The cash benefit includes the employer’s portion of required FICA, FUTA, and SUTA.

(e) The cash benefit is directly deposited into a participant's ICP designated checking account.

(9) SERVICE BUDGET.

(a) The service budget must identify the cash benefit, the discretionary and contingency funds if applicable, the reimbursement to an employee provider, and all other expenditures. The service budget must be initially approved by a Department or AAA case manager.

(b) The participant may amend the service budget as long as the amendments relate to meeting the participant's service needs and are within ICP program guidelines.

(c) A budget review to assure financial accountability and review service budget amendments must be completed at least every six months.

(10) CONTINGENCY FUND.

(a) The participant may establish a contingency fund in the service budget to purchase identified items that are not otherwise covered by Medicaid or the Supplemental Nutrition Assistance Program (SNAP) that substitute for personal assistance and allow for greater independence.

(b) The contingency fund must be approved by the case manager, identified in the service budget, and related to service plan needs.

(c) Contingency funds may be carried over into the next month's budget until the item is purchased.

(11) DISCRETIONARY FUND.

(a) The participant may establish a monthly discretionary fund in the service budget to purchase items that directly relate to the health, safety, and independence of the participant and are not otherwise covered under Medicaid home and community-based services or delineated in the monthly service budget.

(b) The maximum amount of discretionary funds may be up to 10 percent of the participant's cash benefit not including employee taxes.

(c) The discretionary fund must be approved by the case manager, identified in the service budget, and related to service plan needs.

(d) Discretionary funds must be used by the end of the month.

(12) ISSUING BENEFITS.

(a) The service plan and service budget must be prior approved by the case manager before the first ICP cash benefit is paid.

(b) A cash benefit is considered issued and received by the participant when the direct deposit is made to the participant's ICP bank account or a benefit check is received by the participant.

(c) The cash benefit is exempt from resource calculations for other Department programs only while in the ICP bank account and not commingled with other personal funds.

(d) The cash benefit is not subject to assignment, transfer, garnishment, or levy as long as the cash benefit is identified as a program benefit and is separate from other money in the participant's possession.

(13) CASE MANAGER RESPONSIBILITIES.

(a) The case manager is responsible to review and authorize service plans and service budgets that meet the ICP program criteria.

(b) If a participant is disenrolled, the case manager must review eligibility for other Medicaid long term care and community-based service options and offer other alternatives if the participant is eligible.

(c) At least every six months, a Department or AAA case manager must complete a service budget review to assure financial accountability and review service budget amendments.

(14) HEARING RIGHTS. ICP participants have contested case hearing rights as described in OAR chapter 461, division 025.

(15) ICP eligible participants who were determined eligible before August 31, 2015 may continue his or her current service plan until a new assessment and service plan is completed.

Stat. Auth.: ORS 410.090
Stats. Implemented: ORS 410.070