

TEMPORARY FILING
INCLUDING STATEMENT OF NEED & JUSTIFICATION
For internal agency use only.

Department of Human Services, Aging and People with Disabilities (APD)	411	
Agency and Division Name	Administrative Rules Chapter Number	
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FILING CAPTION

Changes to In-Home Services rules relating to homecare worker cap exceptions

Agency Approved Date: [02-20-2020]

Effective Date: [02-21-2020] through [08-18-2020]

RULEMAKING ACTION

List each rule number separately (000-000-0000). Attach clean text for each rule at the end of the filing

ADOPT:

AMEND: 411-030-0020; 411-030-0033; 411-030-0050; 411-030-0055;
411-030-0068; 411-030-0070; 411-030-0071; 411-030-0072

SUSPEND:

RULE SUMMARY:

Include a summary for each rule included in this filing.

411-030-0020:

Adds new definitions for “Adequately”, “OSIPM” and “Service Need”, and definitions for “Benefit Plan” and “Exception” have been amended to clarify intent and practice.

411-030-0033:

Updates rule to clarify when an individual is not eligible for Medicaid in-home services based on residing in a provider owned, controlled, or operated residential setting.

411-030-0050:

Minor grammar, punctuation, formatting and other changes were made to improve readability and better align rules with current Department practice.

411-030-0055:

Minor clarifications were made to better align rules with current Department practice.

411-030-0068:

Adds requirement to submit a three consecutive day log to document assistance needs; clarifies circumstances when shift service hours may be reduced; and clarifies the criteria DHS uses to make a final determination.

411-030-0070:

Minor grammar, punctuation, formatting and other changes were made to improve readability and better align rules with current Department practice.

411-030-0071:

Timeframes have been changed to reflect calendar days. Responsibility to assist with creating less costly plan and manage employer responsibilities are tied to the Exception process. Duration of the exception has been changed from one year to valid through the end of the individual's service plan end date. Minor grammar, punctuation, formatting and other changes were also made to improve readability and better align rules with current Department practice.

411-030-0072:

Timeframes have been changed to reflect calendar days. Circumstances under which an exception to the Homecare Worker Cap will be considered have been updated. Maximum timeframe for an approved exception has been shortened from one year to 90 days. Information on how and when to ask for an extension has been added. Information on when a request will be denied has been added.

STATEMENT OF NEED AND JUSTIFICATION

Need for the Rule(s):

Division 411, chapter 030 rules provide the basis for over 53% of APD Consumers to receive APD Medicaid funded services in their own and family homes.

Justification of Temporary Filing:

The Department finds failure to act promptly to amend OAR chapter 411, division 030 will result in serious prejudice to the public interest, the Commission, and Aging and People with Disabilities. These rules need to be adopted promptly so that program intent can be clarified for sustainability and consistent application. These rules also need to be amended immediately because recent administrative hearings demonstrated the lack of clarity and ability to manage APD's limited resources as intended while continuing to meet in-home consumers' needs.

Documents Relied Upon, and where they are available:

Signature

Date

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

**CHAPTER 411
DIVISION 30**

IN-HOME SERVICES

411-030-0020 Definitions

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

(1) "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) "Adequately" means sufficient quantity to meet the minimum need as determined by the department.

(32) "Aging and People with Disabilities (APD)" refers to the program within the Department of Human Services primarily responsible for serving seniors and people with disabilities as defined in OAR chapter 411, division 015.

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

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

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

(76) "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.

(78) "Benefit Plan" means the specific authorization, for in-home services authorized under the Consumer Employer Program, Independent Choices Program (ICP), or spousal pay services that is part of the Client Assessment and Planning System and includes set start and end dates for in-home individuals. The Benefit Plan authorization is developed with the individual.

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

(109) "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.

(1140) "Central Office (CO)" means the unit within the Department responsible for program and policy development and oversight.

(124) "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 allowed service hourspayment rates, and accommodates individual participation in service planning.

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

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

(154) "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.

(165) "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.

(176) "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.

(187) "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.

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

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

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

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

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

(243) "Exception" means ~~the following:~~a variance to APD service limits, granted or denied at DHS' discretion, based on an individual's documented service needs warranting a deviation from the typical services needed by the service population. This definition of exception applies to the following areas of exception which are granted or denied in the Department's discretion:

(a) Maximum hours exceptions as described in OAR 411-027-0050 and OAR 411-030-0071;

(b) Shift services hours over 16 hours per day as described in OAR 411-027-0050 and OAR 411-030-0068;

(c) 40 and 50 hour cap as described in OAR 411-027-0050 and OAR 411-030-0070(1).

~~(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 described in OAR 411-030-0072.~~

~~(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.~~

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

(265) "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.

(276) "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.

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

(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 paid 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 Oregon Health Authority. Addictions and Mental Health Division.

(298) "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.

(3029) "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.

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

(324) "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.

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

(343) "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.

(354) "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 when the individual resides in a living arrangement that meets the criteria described in OAR 411-030-0033.

(~~365~~) "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.

(~~376~~) "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.

(~~387~~) "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.

(~~398~~) "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.

(~~4039~~) "Oregon Project Independence (OPI)" means the program of in-home services described in OAR chapter 411, division 032.

(41) "OSIPM" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIPM is Oregon Medicaid insurance coverage for individuals who meet eligibility criteria as described in OAR chapter 461.

(~~420~~) "Participant" means an individual eligible for the Independent Choices Program.

(~~434~~) "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 with input and approval from the individual.

(~~442~~) "Provider" means the person who renders the services.

(453) "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>.

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

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

(486) "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.

(497) "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.

(5048) "Service Period" means two consecutive workweeks for a total of 14 days.

(5149) "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.

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

(534) "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.

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

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

(564) "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

(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 or is residing. ~~A provider-owned or rented dwelling may meet the requirements for a limited adult foster home as described in OAR 411-050-0605.~~ in a provider owned, controlled or operated residential setting.

Stat. Auth.: ORS 409.050, 410.070, 410.090

Stats. Implemented: ORS 410.010, 410.020, 410.070

411-030-0050 Case Management

(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

(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 extra 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 as 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 prior-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 or other liability incurred 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

(1) An individual is only eligible for shift services if the assessment and submission and review of three consecutive day log 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. To meet this subsection, the individual (or if applicable their representative) or the case manager must submit a log detailing the performance of all ADL and IADL tasks as defined in the rules for three (3) consecutive 24-hour periods. The log shall include the name of the task, the action performed and the duration of the task. The log must be acceptable to the Department to qualify.

(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) Shift services hours may be reduced from the maximum of 16 hours a day for any of the following reasons:

- (a) Reduced frequency or duration of an ADL need.
- (b) Durable medical equipment or home modification reduces need for assistance.
- (c) Individual preference.
- (d) Natural supports.
- (e) Provided or funded by another agency.
- (f) IADL hours due to small living space.

(4) DHS Central Office shall make the final determination of eligibility for shift services and number of hours up to 16 hours per day by using the criteria in sections 2 and 3 of this rule.

~~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

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

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

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

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

(2) MAXIMUM SERVICE PERIOD HOURS FOR ADL.

(a) The planning process uses the following maximum hours limitations for each service period 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 any of the following defined reasons:

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

(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 any of the following reasons:

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

(F) Small living space.

(4) When one or more eligible individuals are living in the same household and receiving in-home services, the total number of hours authorized for ADLs and IADLs may not exceed 24 hours within any 24-hour period in the same household unless an exception is granted as described in OAR 411-030-0071.

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

~~(65) For the creation of a new service plan (resulting from an assessment) beginning September 1, 2016, all homecare workers are limited to 40 hours per week unless 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.~~

~~(ab) The 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 equaleds or exceededs 40 hours per workweek. These homecare workers are limited to no more than 50 hours per week.~~

~~(b) The individual has received a "Weekly Cap" exception. (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.~~

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

(a) Worked to meet an ADL need totaling more than the hours established by section (5)(b) and (c) of this rule.

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

(c) Totaling more than the hours established by section (5)(a) of this rule if an unanticipated need arises that requires the homecare worker to remain awake to provide necessary ADL care.

(~~87~~) A provider may not receive payment from the Department for more than the total amount authorized by the Department on the service plan authorization form under any circumstances. All service payments must be prior-authorized by a case manager. This section shall be waived if the criteria in (6) are met.

(~~98~~) 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.

(~~109~~) 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.

(~~110~~) 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.

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

Stat. Auth.: ORS 409.050, 410.070, 410.090

Stats. Implemented: ORS 410.010, 410.020, 410.070

411-030-0071 Exceptions to Maximum Hours of Service

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

(a) If the Department determines the individual's assessed service needs will not be adequately met within the maximum numbers of hours for a specific ADL or specific IADL as set forth in OAR 411-030-0070, and the Department determines the individual meets all of the requirements in these rules and in OAR 411-027-0050, then the individual shall receive an exception to the maximum hours per ADL and IADL.

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

(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 OAR 411-015-0006 and OAR 411-015-0007 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 tasks not identified in OAR 411-015-0006 and OAR 411-015-0007.

(F) Based solely on choice of individual.

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

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

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

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

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

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

(3) Exception Application Process.

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

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

(B) ~~By r~~Requesting that their case manager complete the SDS 514i exception application form on their behalf; or.

(C) Expressing to their case manager that the authorized service hours are not sufficient to meet their needs.

(b) Prior to processing an application for an exception, the case manager must discuss alternate ways, resources, and service options, if any, to meet the individual's needs consistent with the individual's right to independence, ~~and choice,~~ and responsibility to assist in developing the less costly plans as described in OAR 411-030-0050(2)(a).

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

(d) The Exception Application Form, regardless of who completes the form, must be signed by the individual or their representative in order for the application to be reviewed unless criteria described in OAR 411-030-0071(5)(f) is met.

(e) The CA/PS assessment must have been completed within three months before the exception request, and it must represent the individual's current condition and functioning. If the individual's application for an exception is not within the timeframe noted in this subsection, a new assessment must be completed to document current needs. DHS Central Office may waive this requirement when criteria described in OAR 411-030-0071(5)(f) is met. ~~in special circumstances which must be documented in the individual's file.~~

(f) If the wait for a new assessment threatens the health, safety, or welfare of the individual, as determined by the Department, the Department shall waive the three-month requirement in subsection (e) 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 ~~to complete~~ a task takes to complete each time the task is attempted and an explanation of why, if applicable, the tasks require more time than the maximum allowed hours described in OAR 411-030-0070.

(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 ~~require~~take more than one provider.

(E) The reasons why the current hours do not meet the need, and an explanation of why any less costly options discussed will not meet the need.~~needs of the individual.~~

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

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

(i) The individual, or their representative, is responsible for ensuring that sufficient documentation is provided. A case manager shall assist the individual 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, SDS 514i. The form must be complete, signed by the individual, or their representative unless criteria described in OAR 411-030-0071(5)(f) is met, and accurate.

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

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

(B) Care provider time logs detailing- the performance of all ADL and IADL tasks requiring assistance and as defined in the rules for three (3) consecutive 24-hour periods. The log shall include the name of the ADL/IADL task, the action performed and the duration of the task. The log must be acceptable to the Department to qualify. ~~the support needs of the individual throughout the day;~~ and

(C) Any rRelevant 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; or

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

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

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

request. The individual, or their representative, may appeal any unfavorable decision.

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

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

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

(g) If DHS Central Office determines that it needs additional information, DHS Central Office 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 individual, or their representative, within two business days that additional information is needed.

(h) The individual, or their representative, or case manager must provide the requested information to DHS Central Office within 14 calendar days of the Department's request. The request for additional information will specify the due date and explain how to submit the required information.

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

(B) If the individual fails to timely provide the requested information, DHS Central Office will complete the review based on the documentation in its possession. DHS Central Office has

14 days from the date of the individual's deadline for additional information to complete the review.

(C) If the individual, 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 individual's response will be considered a new request for an exception, with a new effective date.

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

(E) The individual 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 an individual's reasonable control.

(i) For each Exception Application:

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

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

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

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

(6) Exception Application Reviews and Decision Making.

(a) All exception applications must be for hours of services and supports provided by APD. This means that the need must meet the definitions in each ADL or IADL and match the tasks and assistance types ~~defined-described~~ in OAR 411-015-0006 and OAR 411-015-0007~~these rules~~.

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

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

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

(B) Treatments that may drive care needs;

(C) Diagnosis that may drive care needs;

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

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

(F) The reasons supporting~~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 ~~driv~~supporting the increased duration and frequency.

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

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

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

(G) Whether ~~or not~~ denying the exception would result in substantial unmet needs of the individual that may jeopardize the individual's health and safety.

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

(A) The availability of natural supports as defined in OAR 411-030-0020(~~3839~~);

(B) Durable Medical Equipment or assistive devices or 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 individual choice;

(f) The Department may reduce the requested hours if:

(~~GA~~) Requested hours do not meet ADL and IADL definitions; and/or

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

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

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

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

(7) Notification.

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

(b) Notification shall include:

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

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

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

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

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

(F) The duration of the exception.

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

(8) Duration. An exception is valid for the period defined in the notice, not to exceed the individual's service plan end date~~one calendar year~~.

(9) Reassessments.

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

(b) Exceptions may-will 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

(1) An individual receiving in-home service hours may be eligible for an exception to the hourly cap on homecare worker weekly hours as defined in OAR 411-030-0070(5)(b) and (c), if:

(a) †There are specific service needs that are not able to be met by other, resources, homecare workers or providers and

(b) The individual or their representative is appropriately managing their Consumer Employer Responsibilities as described in OAR 411-030-040(4)(a-f).

(2) An individual, ~~or~~ their representative, or Case Manager may request an exception to the homecare worker cap orally or in writing if the individual believes their situation meets the criteria in (1) and (5).

(3) Exception to Homecare Worker Cap Application Process.

(a) Before processing an exception application for the homecare worker cap, the case manager must follow OAR 411-030-0050(2)(a)(B) and discuss with the individual or their representative alternative ways, if any, to meet the individual's needs. This includes discussing:

(A) The individual's responsibility to assist in developing less costly service alternatives described in OAR 411-030-0050(2)(a)(A); and

(B) Management of the Consumer Employer Responsibilities described in OAR 411-030-0040(4)(a-f).

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

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

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

(B) Clearly describe the reason the homecare worker cap is not appropriate ~~for~~ to meet the individual's service needs.

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

(4) ~~All e~~Exceptions to the homecare worker cap ~~in this section~~ must be prior approved by DHS Central Office before payment will be made except when circumstances meet criteria in OAR 411-030-0070(6)(a).

(5) DHS Central Office may shall grant an exception to the homecare worker cap if the individual or their representative continues to demonstrate the ability to engage in and manage their consumer employer responsibilities related to recruiting, hiring, and training workers, and at least one of the following are met:

(a) In the individual's geographic area ~~There is an insufficient number of homecare workers to provide the needed care to the meet the individual's service plan, and, despite efforts to find or identify providers,~~ 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 for the specified time period in the notice of cap exception approval, or until a replacement homecare worker can be hired, whichever comes first;

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

(d) A homecare worker does not show up when scheduled due to weather, illness, or any reason and needs are time-sensitive and would risk harm to the individual if a delay in services occurs. The circumstance meets criteria in OAR 411-030-0070(6)(a) 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 individual's health and safety if the care for those needs is not received.~~

(e) There is an emergent or urgent need of the individual such that postponing care until another worker could arrive or going without care would more likely than not result in the need for medical intervention; or

(f) The individual has specific unique or complex ADL or IADL needs requiring continuity of care from a trained existing provider until additional providers are found and trained.

(6) The Department may approve exceptions on a temporary basis or for the service plan period. 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 individual about the outcome of the request for an exception to homecare worker cap within 30 days of the request.

(8) Notification shall include:

(a) For approval:

(A) The name of the particular homecare worker(s) approved;

(B) The approval start and end dates; and

(C) The number of hours they may exceed the cap.

(b) For denial:

(A) The reason the request was denied or partially denied; and

(B) ~~provide~~ information on hearing rights and how to request a hearing.

(9) An approved exception to the homecare worker cap ~~that has been granted~~ is valid for the period defined in the notice, not to exceed 90 calendar days~~one year. Exceptions granted in subsection (5)(b) and (c) of this rule are time limited and may not exceed 30 calendar days.~~

(10) When the conditions for initial approval of a homecare worker cap are likely to continue beyond the approval period, in order to get re-approved without an interruption, a new request must be submitted on the SDS 514i form by the individual 15 calendar days prior to the approval period end date and include documentation describing actions taken and any progress

made in reducing the need to exceed the homecare worker weekly hours cap.

(11) An exception to the homecare worker cap that has been granted is valid for only the specific individual consumer-employer and the homecare worker identified in the approval notice.

(12) The Department shall deny a request to exceed the Homecare Worker Cap if:

(a) The request does not meet the criteria in section (1) and one or more criteria in (5)(a)-(f) of this rule;

(b) The homecare worker in question is working for more than one individual;

(c) The individual or their representative fails to manage the Consumer-Employer Responsibilities described in OAR 411-030-0040(4)(a)-(f), as determined by the department;

(d) There is a conflict of interest created by the homecare worker also acting as a representative for an individual (OAR 411-031-0040(1));

(e) There exists a more cost-effective or more feasible way to safely meet the individual's needs;

(f) The request is based solely on consumer preference;

(g) Exceeding the cap is recurring to the extent that the need for additional workers becomes predictable as determined by the department; or

(h) When there are additional qualified providers available to select and the consumer has chosen not to select them.

(13) No exceptions to homecare worker's cap may exceed an average of 16 hours a day per pay period. This limit applies per homecare worker.

(14) The individual is responsible for reducing or minimizing the need to exceed the cap by using other resources when available including within approval periods.

Stat. Auth.: ORS 409.050, 410.070

Stats. Implemented: ORS 410.070