Question and Answer: Service Planning and Payment Authorizations Webinar July 21 and 22, 2026

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Backdating services

Q: If a 4105 has been Provided. To the HCW authorizing fact dated hours, is the HCW entitled to work those hours, or can the office correct it by rejecting the authorizations?

A: 4105s should not be backdated. If you believe a case may need to have hours authorized prior to the date a 4105 is sent, please staff those with your lead first and policy as necessary.

Q: If a client calls and leaves a voicemail with HCW changes in the middle of a pay period and the CM Is out, are we able to make those changes the next business day?

A: As long as the consumer employer notified the department within two days of the change, we can take action to authorize the changes. The department has seven days to implement changes to providers after notification.

Q: In an established case, if no extension was applied and eligibility wasn't approved, then we prorate hours starting on the day we approved SELG. The HCW hours are short. Can the HCW ask for a hearing?

A: No, an HCW cannot ask for a hearing on hours. They can take pay disputes through the OHCC process.

Q: If a consumer has an HCW who calls out and the consumer asks another HCW to take the shift and tells us after the fact, is this considered backdating?

A: As long as the consumer employer notified the Department within two days of the change, we can take action to authorize the changes. The Department has seven days to implement changes to providers after notification.

Q: What if the natural support is the backup caregiver listed in the risk plan and chooses to have another caregiver work instead and informs the CM days later?

A: As long as the consumer employer notified the Department within two days of the change, we can take action to authorize the changes. The Department has seven days to implement changes to providers after notification.

Q: If a client notifies me weeks later that they fired a caregiver, am I not able to end the ONGO effective the date they were fired?

A: It depends. The Department has the responsibility of notifying the provider of payment authorizations that have ended. If that did not happen and the provider worked, we could be responsible for payment. If the consumer states the provider did not work at that time, but there is time claimed please follow the process to report fraud.

Q: What about an increase in hours when the consumer reports an increase in need, but the assessment isn't completed until later due to workload? Can we backdate the increase?

A: No, we cannot. If there is an increase in need the assessment must be completed and a new authorization provided before an increase in hours can be sent to the provider via written prior authorization.

Form 598 questions

Q: When the HCW does not sign the 598, does that mean they can’t work?

A: The HCW is not required to sign the 598. An IHCA is required to sign the 598, but it is not required to be returned before the IHCA begins work. If we do not receive the 598 back, we can remove the IHCA as the provider. However, the HCW is still authorized to work, we do not need a returned 598.

Q: Can the provider start once the 598 is mailed, or do we have to wait until it's signed?

A: Yes, the provider can start once it has been mailed.

Q: Can we email the HCW the 598 and 4105 even though they can't receive secure emails?

A: No, it can only be sent via secure email or mail.

Q: If someone is in the nursing facility and discharging home, does the 598 provide information to the in-home agency?

A: It can, but it is always best practice to send a copy of the 002N to the IHCA to review before accepting a consumer.

Q: When we authorize and send the 4105 to the HCW, does the 598 go to the HCW or the consumer?

A: The 598 goes to the HCW and the consumer receiving services and a copy goes to Laserfische. The consumer receiving services should sign the 598 and return it but would not delay the start of service.

Q: To clarify, we cannot open a POC in MMIS until the IHCA has signed and returned a 598?

A: No, a POC can be opened before the return of the 598, we do not want to delay services to the consumer.

Form 4105 questions

Q: If the provider doesn't need the 4105 in hand before they start, is the date it is mailed sufficient?

A: Yes, the date they mailed the 4105 is sufficient.

Q: What option do we use the end an HCW on the 4105?

A: You would select the option that says, "As of X date, your hours have been reduced to" and then you would enter zero for the hours. The date you enter would be the first date that they no longer have hours. For example, if the last day worked was January 17, you would enter effective 1/18/26 you have zero hours.

Q: Is the 4105 all that is required to end an authorization, or is a phone call or email also required?

A: Yes, the 4105 is required to end an authorization for an HCW.

Q: Can we send the 4105 in advance when a consumer is temporarily in a facility but returning home?

A: Yes, this could be done in scenarios where it is certain that a consumer will return home on a specific date. Be sure to follow the case closely and update the 4105 if something changes and the consumer does not discharge.

Q: If a consumer passes away, does a 4105 need to be sent to the HCW?

A: Yes, this would be best practice. The HCW may not know the consumer has passed away. It also helps prevent situations where an HCW would claim time after the consumer passed for tasks like cleaning the home, etc. It is also important to send a 546N to support staff to end the ONGO.

Q: To clarify, we cannot open a POC in MMIS until the IHCA has signed and returned a 598?

A: A POC can be opened before the return of the 598, we do not want to delay services to the consumer.

Q: When sending a 4105 to end an HCW, do they need a 10-day notice?

A: An HCW does not need 10-day notice.

Q: What if the IHCA quits? Do you still need to send the 4105?

A: IHCAs do not get the 4105. If an IHCA quits, yes, the 546 should still be sent, confirming the authorization has ended. If an HCW quits, a 4105 should still be sent to confirm they are now allotted zero hours for that consumer.

Q: Will the 4105 be updated?

A: It currently tells the HCW to ask the consumer-employer for the task list. There is no current plan to update the 4105.

Q: Does the consumer verbally approve the start of the care plan, or can the HCW say they have been approved to start?

A: The consumer drives the plan; the HCW cannot be the Consumer Employer Representative to start and end services for a provider. The HCW may call to say they are starting for a consumer, but this must be confirmed by the consumer receiving services.

Form 546, 546SF and SPAN questions

Q: 546SF – How do we let an IHCA know they are authorized to work if the short form only covers one pay period?

A: IHCAs are familiar with the 546SF, so they are likely aware that it would only be for the timeframe listed on the short form. However, best practice would be to clearly put it in the email as well.

Q: I get a lot of IHCAs that want a 546 and a 598 before they will screen the consumer. What should we do?

A: Central Office has been working with IHCAs to move toward asking for the 002N or the assessment summary before screening a consumer. While you can send a copy of the task list and the hours, it is important for the IHCA to understand that they are not a guarantee of those hours until they have accepted the consumer on services and developed a plan.

Q: Can the CM approve emergency hours with the 546SF without supervisor or Central Office approval?

A: No, it would require approval. The hours would be added to the service plan, which would require Tier two or three rights to approve.

Q: Does the standard 546 also need to be uploaded to Laserfische?

A: Yes, the 546 is required to be sent to Laserfische.

Q: I typically send a new 598 and 546 to the IHCA when cases are extended. Is this best practice?

A: This is exactly what should happen when an extension is completed.

Q: Just to clarify, CMs need to end the service plan, send the 546SF to the voucher team, then generate a 546 and send it to the IHCA?

A: If we are ending the plan, we would not need the 546SF, but we would need to send a 546 to the IHCA and make it clear in the email that they are no longer authorized to provide services.

Q: When we end authorization for an IHCA and send the 546, do we send one that no longer lists the agency?

A: You would just send a copy of the one that you ended noting that it has an end date and they cannot provide services after that date.

Q: So, the 546 is not closed the day before death?

A: The benefit and service plans are ended on the date of death. This allows HCWs and IHCAs to claim hours on the date of death. The 4105 and 546 would also end on the date of death. CBCs and NF payment authorizations would end the day before the date of death.

Q: I am not clear on what to send when the service plan ends and it is an HCW rather than an agency.

A: We would send a 4105 to the HCW to end the plan. We would send a 546 to the IHCA to end services.

Q: It was mentioned we send the SPAN, 598 and 4105 to HCWs. The SPAN is new to me to send the HCWs; did I hear that correctly?

A: We would not send the SPAN to a provider. It was mentioned as a step that a CM would take when approving the plan. Send the SPAN to the consumer, send the 4105 and 598 to the HCWs.

Extensions, exceptions, HCW payments and provider scenario questions

Q: If an extension request is pending, should we continue the current authorization until a decision is made?

A: If we have not told the provider they are no longer authorized, yes, we would continue the authorization.

Q: If financial eligibility is still pending, should an extension be requested or should services end?

A: For ongoing eligibility, yes, we would need to request an extension. If a consumer has not been given a closure notice, then they are still entitled to benefits.

Q: How long can a case remain on an extension?

A: Extensions should not be done for longer than 90 days. Best practice would be to prioritize assessments that have been extended previously and to extend newer assessments rather than continuing to extend the older assessment.

Q: If AVS is delayed, should an extension be requested?

A: If it is for a consumer currently receiving services, yes. If it is for a newly applying consumer, then the SELG due by date in ONE should be extended to allow for additional time to make a determination.

Q: If an extension expires before eligibility is determined, what should staff do?

A: If the assessment needs to be done, efforts should be made to complete it. An assessment should not be extended solely to wait on the annual financial redetermination.

Q: If Central Office has not responded to an extension request before services expire, should services continue?

A: Yes, if we have not provided any notice to the consumer about their eligibility ending, we have to allow service eligibility to continue.

Q: Can multiple extensions be requested for the same case?

A: An extension should only be done for 90 days. In certain circumstances, we can consider extending the assessment beyond that timeframe, but it should be rare.

Q: If the consumer is cooperating but eligibility is delayed, should services continue under an extension?

A: Yes, if the consumer has not been informed that their eligibility is ending, they must continue.

Q: When should a timely notice be sent instead of requesting an extension?

A: A timely continuing benefit notice must be sent with at least 10 days' notice but can be sent earlier. If there is a scenario where we are considering an extension vs closure, best practice

would be to extend to the minimum necessary date to allow the consumer time to provide anything we requested on a pending notice and issue the closure notice.

Exceptions questions

Q: What situations qualify for an exception request?

A: Exceptions are a consumer driven process, so a consumer requesting services can request one at any time.

Q: Can emergency situations be approved before receiving Central Office approval?

A: Please see the Exceptions to the HCW Hourly Cap **Document** for scenarios when Central Office approval would be required.

Q: Does every emergency request require a 546SF?

A: Any temporary change in hours amongst providers must be documented and the 546SF is the easiest way to do that, rather than creating short-term plans in Oregon ACCESS on the 546.

Q: Who should staff contact regarding exception requests?

A: For in-home exceptional requests please email spd.exceptions@odhsoha.oregon.gov.

HCW payment questions

Q: If an HCW works before the authorization is completed, can they still be paid?

A: An HCW is only authorized to work with written prior authorization. Please staff with a lead and then policy as necessary on a case-by-case basis.

Q: If an HCW provides care while paperwork is pending, how is payment handled?

A: An HCW is not authorized to receive payment for work until all eligibility is met, a consumer has been approved for LTC Services, and written prior authorization has been sent.

Q: If an HCW exceeds 120 hours because they are covering another caregiver, how is payment handled?

A: Please refer to OAR 411-030-0070 sections (6) and (7)(a).

Q: Can two HCWs split hours differently than originally authorized?

A: Hours must be authorized. If there is a change in how the consumer wants hours authorized, the service plan should be adjusted to reflect that.

Q: If an HCW fills in for another caregiver for only a few days, does a new authorization need to be completed?

A: Yes.

Q: How should payment be handled when relief care is provided?

A: As long as the consumer employer notified the Department within two days of the change, we can take action to authorize the changes. The Department has seven days to implement changes to providers after notification.

Q: Can payment be made if the consumer changes caregivers without notifying the office until later?

A: The consumer needs to be notified by the Department within two days of the change. Please communicate this to consumers on your caseload.

Q: How should payment be handled when a provider begins work based on verbal approval?

A: Providers may only be authorized to begin work with written prior authorization.

Provider and caregiver change questions

Q: What should staff do when a consumer changes HCWs unexpectedly, an HCW quits or authorization of replacement caregivers?

A: As long as the consumer employer notified the Department within two days of the change, we can take action to authorize the changes. The Department has seven days to implement changes to providers after notification.

Q: What if a family member temporarily provides care until another HCW is available?

A: This would be considered natural support.

Q: If the backup caregiver identified in the risk plan cannot provide care, what should happen next?

A: The consumer would need to identify another provider.

Q: Can another HCW provide coverage before paperwork is completed?

A: All eligibility must be determined, and prior authorization sent prior to hours being authorized for any provider.

Q: If the consumer reports the caregiver change several days later, how should the authorization be handled?

A: It depends. If this is a new provider, they need to receive prior authorization before they are authorized to work. Best practice would be to staff these situations on a case-by-case basis with your lead and policy if necessary.

Q: If the provider refuses services, does a new authorization need to be completed?

A: Yes, if there is a new provider that new provider would need a new authorization for them to be prior authorized hours.

Provider notification questions

Q: When should providers be notified that services have been approved?

A: Services can begin as soon as they are prior authorized so if there is a provider ready to work, we should send the authorization as soon as possible.

Q: What notification is required when services are reduced?

A: The consumer receiving services is required to receive written notification of the reduction with at least 10 days' notice before the date the reduction begins. This will likely be on the SPAN but can be on a 540. The HCW should receive notification on the 4105 and the IHCA should be notified via a 546.

Q: What notification is required when services are ended?

A: The consumer is required to receive written notice of the closure at least 10 days before the closure occurs. This would be on a SPAN or 540. The HCW should receive notification on the 4105 and the IHCA should be notified via a 546.

Q: Does mailing the authorization count as notification?

A: Yes.

Q: Is verbal notification sufficient before written notice is received?

A: No, it is not. It must be in writing.

Q: Does the consumer have to approve services before the provider is notified?

A: The consumer must be eligible before we can give prior authorization to a provider.

Q: Who is responsible for notifying the provider when changes are made?

A: The consumer can make decisions on their service plan, but the CM is responsible for providing written authorization for payment authorization. This would include providing written notification that a provider is no longer authorized.

Status quo and Continuing Benefits questions

Q: If a hearing is requested, do services continue?

A: It depends. A consumer can request Continuing Benefits as part of the hearings process. This would allow them to receive the same number of hours in a reduction case or continue to

receive benefits in a closure scenario. Certain requirements must be met in order for consumers to be approved Continuing Benefits so not all cases are approved. If the consumer does not request Continuing Benefits, the adverse action would go into effect (reduction in hours or the closure of benefits). Whether the consumer requests continuing benefits or the adverse action goes into effect, the case remains in that status until the hearing is held and the Administrative Law Judge (ALJ) decides at which point the assigned hearing representative will give further instruction.

Q: How do status quo benefits affect provider authorizations?

A: If hours, etc. stay the same, we would still need to authorize the provider.

Q: If the consumer remains financially eligible but paperwork is pending, should services continue?

A: Unless the consumer has been given notice that their benefits are ending, they must continue.

Q: What happens when status quo benefits end before required forms are returned?

A: If the consumer still has time on the pending notice or Request for Information (RFI), we have to allow benefits to continue. If they have not provided the requested information, we would extend the benefit long enough to meet the Timely Continuing Benefit Notice requirements.

Q: Does continued authorization apply to HCWs and IHCAs the same way?

A: Yes, it does.

Risk mitigation questions

Q: If increased hours cannot be approved immediately due to workload, what is our responsibility for risk mitigation?

A: Staff should identify the health or safety concern and take steps to reduce the risk while the request is being reviewed. A workload delay does not allow staff to tell a Homecare Worker

(HCW) to work additional hours before those hours are authorized. HCW services must be authorized before the work occurs, except in the limited emergency situations allowed under Oregon Administrative Rule (OAR) 411-030-0070 and the HCW Collective Bargaining Agreement (CBA).

When there is an urgent health or safety concern, staff should prioritize the case and complete the review as quickly as possible. If the consumer is already eligible and the Department has enough information to approve the additional hours, staff should use the available expedited authorization process rather than wait for normal processing.

A workload backlog, by itself, is not a reason to approve hours after they have already been worked.

Q: What options are available when immediate services are needed but authorizations cannot yet be completed?

A: Staff should first determine what is preventing the authorization. If the consumer is already eligible and staff have enough information to determine the service needs, the authorization should be expedited. When appropriate, written authorization may be provided through secure email when the service cannot wait for normal system processing.

If there is an unexpected emergency and critical care is needed to protect the consumer's health or safety, staff should follow the emergency provisions in OAR 411-030-0070 and the HCW CBA.

If the consumer's eligibility has not yet been determined, HCW services cannot be authorized as Medicaid services. Staff should prioritize the eligibility and assessment work and help identify other available supports that may reduce the immediate risk.

The emergency process does not create Medicaid eligibility when eligibility has not yet been established.

Q: How should risk plans be used while waiting for eligibility or assessment completion?

A: A risk plan should explain how identified health or safety risks will be addressed while the Department completes its work.

The risk plan may include:

- the specific health or safety concern;
- supports that are already available;
- natural supports or community resources that may help;
- equipment, technology, or other temporary supports that may reduce the risk;
- who is responsible for each action;
- when staff will follow up; and
- when the situation must be escalated because the risk has increased.

A risk plan does not replace an eligibility determination, assessment, service plan, or prior authorization. Staff should not use a risk plan to tell an HCW to begin working unapproved hours or to promise that services will later be approved or paid. If the consumer is already receiving services, the current authorized service plan remains in effect until additional hours are authorized, unless the situation meets the emergency requirements in rule and the CBA. A risk plan does not replace an eligibility determination, assessment, service plan, or prior authorization. Staff should not use a risk plan to tell an HCW to begin working unapproved hours or to promise that services will later be approved or paid. If the consumer is already receiving services, the current authorized service plan remains in effect until additional hours are authorized, unless the situation meets the emergency requirements in rule and the CBA.

Q: What should staff do when delaying services creates a potential health or safety risk?

A: A health or safety risk should cause staff to expedite the decision, when possible, not bypass the eligibility or authorization requirements.

Staff should:

1. Determine whether the consumer is already eligible for the service.
2. Determine whether there is enough information to decide about the additional service needs.

3. Prioritize and escalate the case to local leadership when the delay may affect the consumer's health or safety.
4. Follow the emergency provisions in OAR 411-030-0070 and the HCW CBA when the situation meets those requirements.
5. If eligibility is still pending, develop an interim risk plan and identify other available supports while eligibility and the assessment are completed.

A health or safety concern makes the case more urgent, but it does not, by itself, establish Medicaid eligibility or authorize HCW services.

Hospitalization questions

Q: Can a provider be paid while the consumer is hospitalized?

A: Generally, no they cannot. APD-PT-20-112 provides guidance on consumers needing cognitive assistance while hospitalized and the hospital attendant care policy.

Q: If a consumer is hospitalized for only a few days, do services need to be ended?

A: The service plan section of Oregon ACCESS can end, but do not end the benefit line at the top. This could cause a consumer to lose their medical benefits.

Q: How should authorizations be handled when a consumer is admitted to a nursing facility?

A: If the consumer had in-home services prior to entering the NF, the in-home provider should be notified that they are no longer authorized for hours. If the consumer has exhausted their skilled NF benefit, it would be appropriate to open an NF benefit line.

Q: If a consumer is discharged from the hospital, when can services begin again?

A: As soon as they are discharged, services can begin. The in-home providers should be authorized in writing as soon as possible.

Q: Can housekeeping services be authorized before a consumer returns home from the hospital?

A: Generally, no. Day of return could be acceptable on a case-by-case basis.

Q: How are same day transitions between the hospital, nursing facility and home handled?

A: Facilities such as nursing facilities or CBC are not paid for the date of discharge so in-home services can be authorized the same day. This is the same for hospitals.

Q: If a consumer enters a facility temporarily, should the authorization be ended or suspended?

A: The in-home provider should be notified, and the authorization should be ended.

Q: Are there any services that may continue while a consumer is temporarily out of the home?

A: No, there are not.

Q: If an HCW accompanies a consumer to the hospital, are those hours payable?

A: If it meets the criteria in APD-PT-20-112 yes, they are. If it does not meet that criteria, then no, the hours would not be payable.

Q: What happens if a consumer is discharged sooner or later than expected?

A: It is important to keep in contact with the in-home providers on discharge and the status as much as possible. If they are discharged early and the provider was not prior authorized, we cannot pay for the hours. If the discharge is delayed, the authorization would need to be updated to reflect the correct date.

Consumer death questions

Q: What should staff do when a consumer passes away?

A: Services should be closed. Staff may also refer to the Death Checklist for Case Management tool found on the CM Tools website.

Q: Does a 4105 need to be sent when a consumer passes away?

A: Yes, for all in-home cases.

Q: Does the HCW receive notice that services have ended when the consumer passes away?

A: The CM needs to send notification via 4105.

Q: Does support staff need to receive notification to stop vouchers?

A: Yes, ending ONGO is vital.

Q: Should the authorization end on the date of death or the day before?

A: The authorization should end on the date of death. In CBCs, the 512 should end the day before the date of death.

Q: Can an HCW or IHCA be paid for services provided on the date of death?

A: Yes.

Q: Can housekeeping services be authorized after a consumer passes away?

A: No, services may not be authorized after death.

Q: What happens if the consumer dies while services are still being authorized?

A: If eligibility has not been fully determined, hours should not be authorized.

Q: How should final vouchers be handled?

A: Providers may be paid for however many hours they worked to include the date of death. Please end authorizations, zero hours effective the date after death.

Q: If the HCW is a family member, does anything change regarding final payment?

A: No.

Q: What if the office is not notified of the consumer's death until later?

A: Hours would be authorized for the time the consumer was alive. Any hours after that would not be paid and an overpayment may be necessary.

In-Home Care Agency questions

Q: When can an IHCA begin providing services?

A: The date they are sent the 546 and 598.

Q: Does an IHCA have to return the signed 598 before services can begin?

A: No, we do not want to delay services to the consumer while waiting for the return of the 598.

Q: Some IHCAs request the 546 and 598 before they will screen a consumer. Is that correct?

A: It can be provided as part of that process, but the 002N is what should be sent to assist an IHCA in determining if they can meet the needs of the consumer.

Q: How should an IHCA be notified that services have been authorized?

A: The 546 and 598 should be sent to the IHCA via email.

Q: If an IHCA cannot staff the case, what should staff do?

A: IHCAs are responsible for having enough caregivers on staff to meet the needs of all the consumers they serve, 24/7, 365. If they are unable to meet the need, the IHCA Complaint Form should be completed and emailed to mailbox.inhomecare@odhsoha.oregon.gov.

Q: Does an IHCA receive a SPAN?

A: No, they do not.

Q: When an IHCA authorization ends, what paperwork should be sent?

A: They should be sent a 546 with an end date via email. The email should make it clear that the last day of care is XX/XX/XXXX.

Q: Should a new 546 be sent each time a case is extended?

A: Yes, it should.

Q: How should emergency authorizations be communicated to an IHCA?

A: They should be communicated via the 546SF.

Q: If the office mails the authorization, does that delay the start of services?

A: No, they would start the date the authorization is mailed.

Q: What if the IHCA quits providing services?

A: If the IHCA has quit, best practice would still be to send a 546 with an end date.

Q: How should replacement agencies be authorized?

A: Either via the 546 if it is a permanent change in IHCAs or a 546SF if it is temporary.

Contacts and assessment questions

Q: When do required contacts begin?

A: Direct and indirect contacts become required the month that the benefit plan (top of Oregon ACCESS) starts.

Q: Does the assessment have to be completed before services can begin?

A: Yes, all eligibility must be determined prior to services beginning.

Q: Which assessment date is used when determining the effective date?

A: The date the assessment was done with the consumer, not the date the assessment was completed. For example, if the assessment was done on August 5, but not pushed to complete until August 13, we would use August 5.

Q: How do contact requirements apply while eligibility is pending?

A: If eligibility is pending, contacts are not required. However, any conversations, interactions, etc. with consumers should be entered into Oregon ACCESS as part of case documentation. If the consumer is later determined to be eligible for services, those narrations can be added to the CM Services screen as a contact.

Q: How should increase needs be handled when the reassessment has not yet been completed?

A: A reassessment must be completed prior to authorizing any additional hours.

Q: If services are urgently needed before the reassessment is complete, what should staff do?

A: The Department may not authorize hours to begin until all eligibility has been determined, this includes reassessments.

Q: How to CA/PS requirements affect service planning?

A: A CA/PS assessment must be complete prior to sending written authorization for a provider to begin work.

Q: Does the home visit date determine eligibility or authorization?

A: The home visit would determine eligibility, but not authorization since that they would not be considered prior authorization.

Q: When should the benefit plan be completed?

A: Once financial and service eligibility has been determined, the benefit plan should be completed as soon as possible so SELG information is sent to ONE for medical approval, etc.

Q: If a consumer misses an appointment or cannot be contacted, how should that be documented?

A: All attempts at contacts should be documented. If a consumer is missing appointments such as assessments, the process to pend a case using the 4234 form should be followed. If it is direct/indirect contacts that are being missed, please follow the process in APD-PT-20-013 Participation in Waivered Case Management Services for APD.

Q: What documentation is required before authorizing services?

A: In order to authorize a provider, we must send the 598, 4105 to HCWs and 546 to IHCAs. The Department may require documentation from the consumer or provider prior to authorizing services, if it is determined necessary on a case-by-case basis.

Q: Does the assessment need to be updated before increasing hours.

A: Yes.

Q: If a consumer's condition changes before the reassessment is completed, what should staff do?

A: If there is a change of condition prior to the annual reassessment CMs may follow the steps to complete an early reassessment.

Consumer eligibility and service planning questions

Q: How does pending financial eligibility affect service planning?

A: Eligibility must be determined prior to authorizing services to begin.

Q: Can services begin before all eligibility requirements have been completed?

A: No, eligibility must be fully completed prior to services starting.

Q: What happens if financial eligibility is denied after services have already begun?

A: Services may not begin until eligibility has been fully determined. This includes financial eligibility.

Q: How should service plans be handled when OHP eligibility changes?

A: If the consumer is changing between programs such as KPS to APD, the change would be made with the same date as the change in ONE. However, if it is a case of a consumer losing financial eligibility for OHP Plus, services would need to close using the same closure date as ONE. Timely notice needs to be allowed for the service closure. It is important to keep an eye on CM Alerts in ONE to make changes as soon as possible.

Q: How should staff handle delays between financial approval and service eligibility?

A: Whenever possible, work with the consumer applying to keep in communication about what is needed, ways to provide information and to help where you can. We don't want consumers applying for services to fall through the cracks, so keeping in contact is vital.

Q: When should a service plan be updated after eligibility changes?

A: If the consumer is changing between programs, such as APD to KPS, those changes will likely be done after the fact. In that scenario, this is ok, because the hours aren't changing. It is important to keep an eye on CM Alerts in ONE to make changes as soon as possible.

ONE and MMIS questions

Q: When should authorizations be entered into MMIS?

A: As quickly as possible. IHCAs cannot get paid for ongoing services if the POC is not there.

Q: Which system determines the effective date if ONE and MMIS do not match?

A: MMIS should match what is in ONE for financial eligibility and it should match what is created for the SELG. If there is a discrepancy, a CMU ticket should be completed to get MMIS updated.

Q: How should delays in ONE affect service authorizations?

A: If it is at initial application, we cannot approve services without financial eligibility being complete, so no services should be authorized. However, if it is at recertification or other

times, we cannot end services without timely notice. If ONE is pending for information, etc. But notice has not been sent, the consumer remains eligible.

Q: How should delays in MMIS affect provider payment?

A: An IHCA cannot get paid if ONE is not correct or if the authorization is not there. If there is an issue in MMIS, it must be corrected to prevent additional provider payment issues.

Q: Can a POC be opened before all required forms have been returned?

A: Yes, a POC can be created as soon as the 546 and 598 are mailed to the provider.

Q: What should staff do if MMIS will not allow the authorization to be entered?

A: Reach out to a lead, supervisor or Central Office policy staff with assistance in correcting MMIS/POC issues if you are uncertain why you cannot create a POC. Some cases require a CMU ticket, but not all. Please see APD-IM-25-059 MMIS POC Issues Office Hours for information on how to attend weekly POC Office Hours for live assistance in correcting POC issues.

Q: How should staff document delays caused by system issues?

A: Narrate those issues in Oregon ACCESS as well as keeping providers in the loop that there are delays and efforts being made to correct them.

Q: Will there be additional training on using ONE with these policy changes?

A: The guidance around ONE is not changing, rather clarifying the rules that exist around when services can begin. Please see the APD Medicaid Financial Eligibility (MFE) Trainings page for information about available trainings for CMs about ONE.

Q: Are there changes to the MMIS process because of this policy?

A: There are not. MMIS remains the same.

Policy and Central Office questions

Q: What questions should be submitted to Central Office?

A: Questions or case specific scenarios you have staffed with management and/or leads and still are unsure.

Q: Who reviews and approves exception requests?

A: The Medicaid Services and Supports (MSS) unit reviews and approves in-home exception requests.

Q: Who should staff contact when they are unsure how to apply policy?

A: Leads/local management then APD Policy.

Q: Will this guidance be issued through a policy transmittal?

A: This training will be posted in Workday.

Miscellaneous case scenario questions

Q: How should services be handled for consumers experiencing houselessness?

A: A consumer can be houseless and apply for services. However, to be eligible for in-home services, they must meet the requirements in 411-030-0033(2). We cannot authorize services for a consumer that does not meet the living arrangement rules.

Q: How should natural support be documented when they temporarily provide care?

A: Natural support should be added to the service plan if they are actively providing care.

Q: Can a consumer designate another individual to communicate with the case manager regarding caregiver changes?

A: A representative may communicate with the CM about provider changes. The provider may also contact the CM. If this happens the CM should follow up with the consumer to confirm the change.

Q: Is a signed form 3010 required before discussing services with another individual?

A: A release of information or 3010 is not required if discussing care with a provider, such as an HCW or IHCA. It would not be required if we are discussing care with the consumer's representative or Consumer Employer Representative.

Q: What should staff do if a consumer refuses to sign required paperwork but still wants services?

A: The case manager should attempt to get verbal approval and may indicate the approval on the form and in Oregon ACCESS narration. If the consumer refuses to give verbal approval, the case manager should attempt to get forms signed by a guardian or authorized representative. If there is no identified guardian or authorized representative the case manager may then need to send notice of planned action for failure to cooperate during the eligibility determination process.

Q: How should services be handled when the consumer is temporarily unavailable?

A: The case manager should determine if there is an identified guardian or authorized representative. If there is none, the case manager may then need to send notice of planned action for failure to cooperate during the eligibility determination process.

Q: How should unusual situations not specifically addressed in policy be handled?

A: Please staff these with your leads/management. If still unresolved feel free to reach out to APD Policy.

Q: When should staff elevate unique case situations to a supervisor or Central Office?

A: Cases should be staffed with leads/managers prior to elevating to Central Office.

Stand-alone questions

Q: How should services be handled if a consumer moves to another county during the authorization period or while services are still pending?

A: The branch that initially started the process must keep the case until the intake process has been completed.

Q: If multiple policy changes apply at the same time which guidance takes precedence?
A: Every effort is made to provide updated guidance as policies change and to remove guidance that is no longer accurate. However, if there is ever confusion on current guidance, please reach out to the APD Policy mailbox.

Q: Are there any situations where local office procedures may differ from statewide guidance?
A: Local offices must follow Central Office policies and procedures. When statewide guidance is issued, local procedures cannot override it under any circumstances. If anything seems unclear or unusual, please raise the concern with local management or Central Office so it can be reviewed.

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