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

CHAPTER 411
DIVISION 30

IN-HOME SERVICES

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

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

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

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

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

411-030-0020 Definitions
(Amended 07/01/2023)

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.

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

(4) "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.

(5) "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.

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

(7) "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.

(8) "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.

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

(10) "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.

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

(12) "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 hours, 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.

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

(15) "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.

(16) "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.

(17) "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.

(18) "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.

(19) "Department" means the Oregon Department of Human Services (ODHS), APD.

(20) "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.

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

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

(23) "Electronic Visit Verification" means a service which requires hourly providers to clock-in at the beginning of their shift and clock-out at the end of their shift, so all hours worked are captured electronically and paid accordingly.

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

(25) "Exception" means 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 at the Department's full 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 411-030-0072.

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

(27) "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.

(28) "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.

(29) "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.

(30) "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.

(31) "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.

(32) "ICP Participation Agreement" means the form provided by the Department the individual signs indicating that they understand their roles and responsibilities in the ICP program.

(33) "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.

(34) "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.

(35) "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.

(36) "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.

(37) "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.

(38) "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.

(39) "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.

(40) “Misuse of ICP Funds” means using ICP funds for any purpose other than to pay for services to meet Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), approved discretionary fund expenditures or contingency fund expenditures.

(41) "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.

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

(43) "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.

(44) "Participant" means an individual eligible for and enrolled in the Independent Choices Program.

(45) "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.

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

(47) "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.

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

(49) "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 may not be a paid employee provider regardless of relationship to a participant.

(50) "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.

(51) "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.

(52) "Service Period" means specific two consecutive workweeks, defined by the Department, for a total of 14 calendar days.

(53) "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.

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

(55) "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.

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

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

(58) "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

411-030-0022 *(Renumbered 6/1/1993 to OAR 411-030-0050)*

411-030-0027 *(Renumbered 6/1/1993 to OAR 411-030-0080)*

411-030-0033 In-Home Service Living Arrangements
(Amended 8/1/2020)

(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 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

411-030-0040 Eligibility Criteria
(Amended 8/1/2020)

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

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

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

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

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

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

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

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

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

(d) Be 18 years of age or older.

(4) CONSUMER-EMPLOYER RESPONSIBILITIES.

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

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

(B) Supervise and train the homecare worker;

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

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

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

(F) Discharge an unsatisfactory homecare worker; and

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

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

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

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

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

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

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

(d) The Department retains the right to approve the representative selected by an individual. Approval may be based on, but is not limited to, the representative’s criminal history, protective services

history, or credible allegations of fraud or collusion in fraudulent activities involving a public assistance program.

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

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

(5) REPRESENTATIVE.

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

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

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

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

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

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

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

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

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

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

(b) A nursing facility;

(c) Prison;

(d) A hospital; or

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

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

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

411-030-0050 Case Management
(Amended 8/1/2020)

(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 help with safety or health emergencies;

(B) An emergency response system;

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

(D) Resources for emergency disaster planning;

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

(F) Resources for provider and consumer training;

(G) Assistive devices; or

(H) Architectural modifications.

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

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

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

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

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

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

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

(d) The case manager must present the individual or the individual's representative with information on service alternatives and provide assistance to assess other choices when the service provider or service setting selected by the individual or the individual's representative is not authorized.

(3) PAYMENT.

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

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

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

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

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

411-030-0055 Community Transportation

(Amended 8/1/2020)

(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

411-030-0060 Client Employed Provider Program
(Repealed 6/7/2004 – Moved to OAR chapter 411, division 031)

411-030-0065 Administrative Review and Hearing Rights
(Repealed 6/7/2004 – Moved to OAR chapter 411, division 031)

411-030-0068 Shift Services
(Amended 8/1/2020)

(1) An individual is only eligible for shift services if the assessment and submission and review of a time/task log documenting three consecutive days of care provided determines the individual meets the criteria described in section (2) of this rule.

(2) Individuals 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, their representative, if applicable, or the case manager must submit a time/task log detailing the performance of the ADL and IADL tasks as defined in OAR chapter 411, division 015 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 complete and 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, assistive technology or home modification reduces need for assistance.

(c) Individual preference.

(d) Services and supports provided by natural supports.

(e) Services and supports 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 the number of hours authorized for the individual by using the criteria in sections 2 and 3 of this rule.

(5) Exceptions to the 16 hour limit may, at the sole discretion of the Department, be approved if the criteria in 411-030-0071 are met.

(6) An individual may be eligible for a differential rate in accordance with the terms of the ratified collective bargaining agreement described in OAR 411-031-0020, if requested through the Case Manager and 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
(Amended 8/1/2020)

(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) A single homecare worker is limited to 16 hours of awake care during a 24-hour work period.

(6) 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:

(a) The homecare worker’s average paid workweek hours in the months of March, April, and May 2016 equaled or exceeded 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.

(7) 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.

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

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

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

(11) Payment by the Department for Medicaid home and community-based services are only made for the tasks described in this rule as ADL or IADL

tasks. Services must be authorized to meet the needs of an eligible individual and may not be provided to benefit an entire household.

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

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

411-030-0071 Exceptions to Maximum Hours of Service
(Amended 8/1/2020)

(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 number 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 the 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:

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

(B) Requesting that their case manager complete the SDS 514i 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, choice, and responsibility to assist in developing the least costly plan 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.

(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 a task takes to complete each time the task is performed or 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 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.

(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) A caregiver time/task log detailing the performance of the ADL and IADL tasks as defined in OAR chapter 411, division 015 for three (3) consecutive 24-hour periods. The log shall include the name of the ADL/IADL task, the action performed and the duration that it took the provider to perform the task. The log must be complete and be acceptable to the Department to qualify; and

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

(5) Exception Decision Making Authority.

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

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

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

(b) 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 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 calendar 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 calendar 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 described in OAR 411-015-0006 and OAR 411-015-0007.

(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 for 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 for 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 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(40);

(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:

(A) Requested hours do not meet ADL and IADL definitions in 411-015-0006 and 411-015-0007; or

(B) 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.

(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 fewer exception hours, a decision to renew the exception may be made without the consumer's signature as defined in section (3)(d) of this rule The case manager may supply the required documentation as outlined in section (4) of this rule.

(b) Exceptions 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
(Amended 8/1/2020)

(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 411-030-0040(4)(a-f).

(2) An individual, 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, 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 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 to meet the individual's service needs.

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

(4) Exceptions to the homecare worker cap must be prior approved by DHS Central Office before payment will be made except when circumstances meet criteria in OAR 411-030-0070(7).

(5) DHS Central Office may 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 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(7).

(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 ADL or IADL needs requiring care from a trained existing provider until additional providers are found and trained.

(6) The Department may approve exceptions up to 90 calendar days at a time.

(7) The Department shall notify the individual about the outcome of the request for an exception to homecare worker cap within 30 calendar days of the request.

(8) Notification shall include:

(a) For approval:

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

(B) The approval begin and end dates; and

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

(b) For a denial:

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

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

(9) An approved exception to the homecare worker cap is valid for the period defined in the notice, not to exceed 90 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 consumer-employer and the homecare worker identified in the approval notice.

(12) The Department may deny or partially 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 another 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.

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

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

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

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

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

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

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

(A) Cachexia;

(B) Severe neuropathy;

(C) Coma;

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

(E) Late stage cancer;

(F) Frequent and unpredictable seizures;

(G) Debilitating muscle spasms; or

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

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

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

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

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

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

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

(3) PAYMENTS.

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

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

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

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

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

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

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

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

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

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

411-030-0100 Independent Choices Program
(Amended 07/01/2023)

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

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

(3) INITIAL ELIGIBILITY REQUIREMENTS.

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

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

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

(C) Sign the ICP Participation Agreement. Eligibility for the ICP cash benefit may not be backdated prior to the date that the

signed ICP Participation Agreement is received in the local office.

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

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

(F) Demonstrate the ability to manage money as evidenced by timely and current utility and housing payments for the past three months or previous history before hospitalization, community-based care, or nursing facility stays.

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

(H) Complete enrollment with a Department contracted Fiscal Intermediary to provide the required Electronic Visit Verification (EVV) services when available and required by the department.

(I) Not have a history of misuse of the ICP cash benefit.

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

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

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

(c) If a participant is unable to manage the ICP cash payment accounting, tax, or payroll responsibilities and does not have a representative, the participant must arrange and purchase the

ongoing services of a fiscal intermediary, such as an accountant, bookkeeper, or equivalent financial services.

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

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

(4) DISENROLLMENT CRITERIA. Participants may be disenrolled from the ICP voluntarily or involuntarily. Participants who are disenrolled from the ICP may not reapply for six months. After the six-month disenrollment period, an individual may re-enroll and must meet all ICP eligibility requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(K) Failure to meet requirement for EVV federal compliance.

(L) Failure to complete enrollment with the State contracted EVV provider.

(M) Failure to provide any required forms necessary to establish and maintain eligibility for ICP.

(N) The participant is required to request or demand that an ICP provider return any of the funds to the recipient when the services paid for were not delivered.

(O) Misuse of the ICP cash funds.

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

(6) SELECTION OF EMPLOYEE PROVIDERS.

(a) The participant or representative carries full responsibility for locating, screening, interviewing, hiring, training, paying, and terminating employee providers. The participant or representative must comply with Immigration and Customs Enforcement laws and policies.

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

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

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

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

(7) CASH BENEFIT.

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

(b) The cash benefit is calculated by adding the ADL task hours and the IADL task hours that the participant is eligible for as determined in

the CA/PS assessment, at the rates according to the Department's rate schedule.

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

(A) Long-term care community nursing.

(B) Contracted community transportation.

(C) Medicaid home delivered meals.

(D) Emergency response systems.

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

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

(f) The cash benefit may not be used to purchase services from an Adult Day Service provider or licensed care setting.

(g) The participant must establish an hourly rate of pay no less than the federal or state minimum wage, whichever is greater. This must be indicated on the required ICP Employee-Provider Information form for each employee-provider and may only pay the provider the agreed upon hourly rate of pay. The ICP cash benefit may not be used to pay an employee-provider a cash bonus.

(h) The participant must submit the required ICP Employee-Provider Information form each time an employee-provider:

(A) Is hired.

(B) Is fired.

(C) Quits.

(D) Is given an increase or a decrease in their agreed upon hourly rate of pay.

(E) Stops working for the participant for any reason not listed.

(8) SERVICE BUDGET.

(a) The service budget must identify the cash benefit, the discretionary and contingency funds if applicable, the reimbursement to an employee provider, and all other expenditures. The service budget may not exceed the total cash benefit including the sum of all costs listed on the ICP Budget Worksheet. The service budget must be initially approved by the Department or AAA case manager.

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

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

(9) CONTINGENCY FUND.

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

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

(c) Contingency funds may accumulate in the ICP checking account until the item is purchased.

(10) DISCRETIONARY FUND.

(a) The participant may establish a monthly discretionary fund in the service budget to purchase items that directly relate to the health,

safety, and independence of the participant and are not otherwise covered under Medicaid home and community-based services or delineated in the monthly service budget.

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

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

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

(11) ISSUING BENEFITS.

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

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

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

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

(12) CASE MANAGER RESPONSIBILITIES.

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

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

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

(d) The case manager must assist ICP participants in enrolling with a Department contracted Fiscal Intermediary to provide the required Electronic Visit Verification (EVV) services.

(e) The Department must offer additional information, counseling, training (if available), or assistance from an ICP Representative, and have documentation that these steps have been taken, declined, or ineffective before imposing section (4)(b) of this rule.

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

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