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

CHAPTER 411
DIVISION 34

STATE PLAN PERSONAL CARE SERVICES

Table of Contents
(Amended 12/23/2022)

OREGON DEPARTMENT OF HUMAN SERVICES
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OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 34

STATE PLAN PERSONAL CARE SERVICES

411-034-0000 Purpose *(Amended 12/23/2022)*

The rules in OAR chapter 411, division 034 ensure State Plan personal care services support and augment independence, empowerment, dignity, and human potential through the provision of flexible, efficient, and suitable services to individuals eligible for State Plan personal care services served through Aging and People with Disabilities. State Plan personal care services are intended to supplement an individual's own personal abilities and resources.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 410.020, 410.070, 410.710

411-034-0010 Definitions *(Amended 12/23/2022)*

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 034:

(1) “Activity of Daily Living (ADLs)” means those personal functional activities required by an individual for continued well-being, which are essential for health and safety. ADLs for these rules means Basic Personal Hygiene, Medication and Oxygen Management, Mobility, Toileting, Nutrition and Nursing Services.

(2) "Adult" means any person at least 18 years of age.

(3) "Alternative Service Resources" means other possible resources for the provision of services to meet an individual's needs. Alternative service resources include, but are not limited to, natural supports, risk intervention services, Older Americans Act programs, or other community supports. Alternative service resources are not paid by Medicaid.

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

(5) "Assistance" means an individual requires help from another person with the personal care or supportive services described in OAR 411-034-0020.

(6) “Assistance Types” mean assistance from another person in the form of hands-on assistance (actually performing a personal care task for a person) or cueing (redirecting) so that the person performs the task by themselves. Other types of assistance may be defined in specific ADLs or IADLs. Specific assistance types include:

(a) "Cueing" means giving verbal or visual clues during an activity to help an individual complete the activity without hands-on assistance.

(b) "Hands-on" means a provider physically performs all or parts of an activity because an individual is unable to do so.

(c) "Monitoring" means a provider must observe an individual to determine if intervention is needed.

(d) "Reassurance" means to offer an individual encouragement and support.

(e) "Redirection" means to divert an individual to another more appropriate activity.

(f) "Set-up" means getting personal effects, supplies, or equipment ready so that an individual may perform an activity.

(g) "Stand-by" means a provider is at the side of an individual ready to step in and take over the task if the individual is unable to complete the task independently.

(h) "Support" means to enhance the environment to enable an individual to be as independent as possible.

(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 task described in OAR 411-034-0020.

(8) "Assistive Supports" means the aid of service animals, general household items, or furniture used to assist and enhance an individual's independence in performing any task described in OAR 411-034-0020.

(9) "Case Management" means the functions required to determine service eligibility, developing a plan of authorized services, and monitoring the effectiveness of services.

(10) "Case Manager" means a Department employee or an employee of the Department's designee who assesses the service needs of individuals, determines eligibility, and offers service choices to eligible individuals. A case manager authorizes and implements an individual's plan for services and monitors the services delivered.

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

(12) "Child" means an individual who is less than 18 years of age.

(13) "Cognition" refers to how the individual is able to use information, make decisions, and ensure their daily needs are met.

(14) "Community Developmental Disability Program (CDDP)" means the Department's designee that is responsible for plan authorization, delivery, and monitoring of services for individuals with intellectual or developmental disabilities according to OAR chapter 411, division 320.

(15) "Cost Effective" means being responsible and accountable with Department resources.

(16) "Delegated Nursing Task" means a registered nurse (RN) authorizes an unlicensed person (defined in OAR 851-047-0010) to provide a nursing task normally requiring the education and license of an RN.

(17) "Department" means the Oregon Department of Human Services.

(18) "Designee" means an organization with which the Department contracts or has an interagency agreement.

(19) "Developmental Disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(20) "Disability" means a physical, cognitive, or emotional impairment which, for an individual, constitutes or results in a functional limitation in one or more of the activities of daily living in these rules.

(21) “Grocery Shopping” means Grocery Shopping - perform or assist individual in planning for and purchasing basic needs and household items.

(22) "Guardian" for the purpose of these rules means a person or agency appointed and authorized by the courts to make decisions about services for an individual.

(23) “Healthier Oregon” is an OHP Plus equivalent benefit (410-120-1210(4)(h)) for individuals described in 461-135-1080.

(24) "Homecare Worker" means a provider directly employed by an individual to provide hourly in-home services to the eligible consumer per the criteria in the CEP program described in OAR 411-031-0020.

(25) "In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR chapter 411, division 033 and chapter 333, division 536 that provides hourly contracted in-home services to individuals receiving services through the Department or Area Agency on Aging.

(26) "Individual" means the person applying for or determined eligible for State Plan personal care services.

(27) “Instrumental Activities of Daily Living (IADLs)” means certain day-to-day activities or tasks associated with an independent lifestyle. These are not considered to be essential for basic functioning but are regarded as important for maintaining day-to-day quality of life and relative independence. IADLs include housework, laundry, transportation, grocery shopping, using the telephone or other communication equipment, and money management.

(28) "Intellectual Disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.

(29) "Legal Representative" means a person who has the legal authority to act for an individual. The legal representative only has authority to act within the scope and limits of his or her authority as designated by the court or other agreement. Legal representatives acting outside of his or her authority or scope must meet the definition of designated representative.

(a) For an individual under the age of 18, the parent, unless a court appoints another person or agency to act as the guardian.

(b) For an individual 18 years of age or older, a guardian appointed by a court order or an agent legally designated as the health care representative, where the court order or the written designation provide authority for the appointed or designated person to make the decisions indicated where the term “legal representative” is used in this rule.

(30) "Long Term Care Community Nursing" means the nursing services described in OAR chapter 411, division 048.

(31) "Natural Support" means resources and supports (e.g., relatives, friends, significant others, neighbors, 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.

(32) "Older Adult" means any person at least 65 years of age.

(33) "Ostomy" means assistance that an individual needs with a colostomy, urostomy, or ileostomy tube or opening used for elimination.

(34) "Personal Care" means the functional activities described in OAR 411-034-0020(2) that an individual requires for continued well-being.

(35) "Provider" or "Qualified Provider" means a homecare worker that meets the qualifications in OAR chapter 418, division 020 or an In-Home Care Agency that meets the qualifications in OAR chapter 411, division 033 that performs State Plan personal care services.

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

(37) "Representative" means:

(a) A person appointed by an individual or legal representative to participate in service planning on the individual's behalf that is either the individual's guardian or natural support with longstanding involvement in assuring the individual's health, safety and welfare; and

(b) For the purpose of obtaining State Plan personal care services through a homecare or personal support worker, the person selected by an individual or the individual's legal representative to act on the individual's behalf to provide the employer responsibilities described in OAR 411-034-0040.

(c) A HCW may not act as a consumer-employer representative for an individual who employs them.

(38) "Respite" means services for the relief of a person normally providing supports to an individual unable to care for him or herself.

(39) "Service Need" means the assistance with personal care and supportive services needed by an individual receiving Department services.

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

(41) "Service Plan" or "Service Authorization" means an individual's written plan for services that identifies:

(a) The individual's qualified provider who is to deliver the authorized services;

(b) The date when the provision of services is to begin; and

(c) The maximum hours per service period of personal care services authorized by the Department or the Department's designee.

(42) "State Plan Personal Care Services" means the assistance with personal care, ADLs and IADLs described in OAR 411-034-0020 provided to an individual by a homecare worker or In-Home Care Agency.

(43) "Sub-Acute Care Facility" means a care center or facility that provides short-term rehabilitation and complex medical services to an individual with a condition that does not require acute hospital care but prevents the individual from being discharged to his or her home.

(44) “Using the telephone” means assisting the individual in the use of any communication related technology.

(45) "These Rules" mean the rules in OAR chapter 411, division 034.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.020, 410.070, 410.710, 411.675

411-034-0020 State Plan Personal Care Services *(Amended 12/23/2022)*

(1) State Plan personal care services are essential services that enable an individual to move into or remain in their own home while also safely navigating their community. State Plan personal care services are provided in accordance with an individual's authorized plan for services by a qualified provider.

(a) State Plan personal care services are provided directly to an eligible individual and are not meant to provide respite or other services to an individual's natural support system. State Plan personal care services may not be implemented for the purpose of

benefiting an individual's family members or the individual's household in general.

(b) State Plan personal care services are limited to 270 hours per calendar year per individual served by APD or an AAA.

(c) When an individual's State Plan Personal Care service needs exceed the annual maximum of 270 hours an exception must be submitted.

(A) To submit an exception the Local Office (LO) must complete 514PC and submit to Central Office (CO) regardless of the number of hours requested.

(B) If an individual requests an exception, but their service plan does not exceed 270 hours annual the request for an exception may be approved or denied by the LO.

(C) CO has up to 45 days upon receipt of a completed exception request to determine whether an individual's assessed personal care needs warrant exceeding the service plan limitation.

(D) The individual shall receive written notice of the Department's decision.

(2) Personal care services include:

(a) Activities of Daily Living (ADLs):

(A) Basic Personal Hygiene means performing or assisting with activities required to keep an individual healthy, appearance neat, combing/brushing hair, foot care, skin care, mouth care and oral hygiene, and include the following:

(i) Bathing means assisting the individual with cleansing the body, washing hair, shaving, nail care, and using assistive devices when necessary to get in and out of the bathtub or shower.

(ii) Dressing means assisting the individual with putting on, fastening, and taking off all items of clothing, braces, and artificial limbs, including obtaining and replacing items from their storage area in the immediate environment.

(B) Nutrition includes eating and meal preparation as defined below:

(i) Eating means assisting the individual in feeding or fluid intake by any means from a receptacle into the body. Includes monitoring to prevent choking or aspiration.

(ii) Meal preparation means performing or assisting with healthy meal planning and preparation, ensuring special diets are followed, if needed.

(C) Medication or Oxygen Management- assist with medications which are ordinarily self-administered. Includes setting up pill dispensing systems, administering medication, observation to ensure individual is taking medication as ordered, documenting and monitoring any notable side effects, and refilling prescriptions in a timely manner. Assist with use, maintenance, and cleaning of in-home oxygen equipment, monitoring client's condition, ordering and maintaining necessary oxygen supplies.

(D) Mobility means assisting the individual with mobility, transfers and repositioning including turning or adjusting padding for physical comfort or pressure relief and encouraging or assisting with range of motion exercises and the use of devices that assist with mobility.

(E) Toileting means assisting the individual in getting to and from, on and off, the toilet, commode or bedpan for elimination of feces and urine. This includes cleansing after elimination and removing and adjusting clothing as necessary. It also includes Maintaining Continence as defined below:

(i) Catheter care including external cleansing of a catheter, emptying catheter drainage bag, changing external catheter supplies,

(ii) Maintenance bowel care,

(iii) Changing and replacing incontinence products,

(iv) Colostomy or ileostomy Care including, emptying bags, cleaning the stoma and other activities necessary for the safe maintenance and disposal of supplies; or

(v) Cueing to prevent incontinence.

(b) Instrumental Activities of Daily Living (IADLs)

(A) Housework means perform or assist with housekeeping tasks necessary to maintain the individual in a healthy and safe living environment. Only the housekeeping activities related to the eligible individual's needs may be considered in housekeeping.

(B) Laundry- perform or assist with laundering or cleaning of clothing, bedding and other items used by the individual or on behalf of the individual.

(C) Transportation- assist individual in getting to and from necessary appointments and community activities through available means of transportation. This includes mileage reimbursement when community transportation is a required care need. Reasonable mileage reimbursement may only be authorized if the homecare worker or IHCA provider is using their own vehicle.

(D) Grocery Shopping- perform or assist individual in planning for and purchasing basic needs and household items.

(E) Using the Telephone- perform or assist individual in arranging necessary appointments and making desired phone calls or the use of other communication devices.

(F) Money Management- perform or assist with budgeting, making payments for monthly expenses and use of personal funds for desired items and activities.

(c) Cognitive Impairments

(A) An individual may be physically capable of performing ADLs or IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task.

(B) In such cases, personal assistance may include cueing along with supervision to ensure that the individual performs the task properly.

(d) Delegated nursing tasks in accordance with OAR 851-047-0000, OAR 851-047-0010, and OAR 851-047-0030, the RN's written authorization of a delegated nursing task includes assessing a specific eligible individual, evaluating an unlicensed person's ability to perform a specific nursing task, teaching the nursing task, and supervising and re-evaluating the individual and the unlicensed person at regular intervals.

(e) Long Term Care Community Nursing as defined in OAR chapter 411 division 048.

(3) Payment may not be made for any of the following excluded services:

(a) Social companionship;

(b) Adult day services (described in OAR chapter 411, division 066),

(c) Respite, or baby-sitting services;

(d) Care, grooming, or feeding of pets or other animals; or

(e) Yard work, gardening, or home repair.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.020, 410.070, 410.608

411-034-0030 Eligibility for State Plan Personal Care Services
(Amended 12/23/2022)

(1) To be eligible for State Plan personal care services, an individual must:

(a) Be 18 years of age or older.

(b) Have a physical or cognitive impairment that requires the assistance from another person or delegated nursing services to complete at least one of the ADLs described in 411-034-0020(2)(a).

(c) Be a current recipient of an OHP Plus package through Medicaid or Healthier Oregon.

(2) An individual is not eligible to receive State Plan personal care services through APD if:

(a) The individual is receiving services from a licensed 24-hour residential services program (such as an adult foster home, assisted living facility, group home, nursing facility or residential care facility). Individuals in licensed care settings who meet the criteria for SPPC may receive Money Management Services;

(b) The individual is in a prison, hospital, sub-acute care facility, nursing facility, substance abuse treatment facility, state hospital or other medical institution. Individuals temporarily in an acute care hospital may continue to receive Money Management Services.;

(c) The individual's service needs are met through the individual's natural support system (defined in OAR 411-034-0010). Individuals excluded from SPPC because of natural supports but who meet the criteria for SPPC may receive Money Management Services;

(d) The individual's assessed service needs are being met under other Medicaid-funded home and community-based (HCBS) service options of the individual’s choosing. Individuals in other Medicaid

funded HCBS service options who meet the criteria for SPPC may receive Money Management Services in addition to their other services.

(e) The individual's primary driver of need is based on an intellectual or developmental disability, a mental illness or a substance use disorder.

(3) Payment for State Plan personal care services is not intended to replace the resources available to an individual from the individual's natural support system (defined in OAR 411-034-0010).

(4) State Plan personal care services may not be used to replace other non-Medicaid governmental services.

(5) The Department has the authority to close the eligibility and authorization for State Plan personal care services if an individual fails to:

(a) Employ a qualified provider; or

(b) Receive personal care from a qualified provider paid by the Department for 30 continuous calendar days or longer.

(6) State Plan personal care services must not duplicate other Medicaid services but may supplement other state plan or waivered services not otherwise provided in those programs.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.020, 410.070, 410.608, 410.710

411-034-0035 Applying for State Plan Personal Care Services
(Amended 12/23/2022)

(1) Individuals eligible for state plan personal care services as described in OAR 410-172-0790(1) must apply through the local community mental health program or agency contracted with Health Systems Division (HSD). An individual applying for State Plan personal care services that is not eligible for or receiving services through ODDS or APD is referred to the appropriate HSD office.

(2) An individual with an intellectual or developmental disability eligible for or receiving services through the Department's Office of Developmental Disabilities Services (ODDS), a Community Developmental Disability Program (CDDP), or Support Services Brokerage must apply for State Plan personal care services through the local CDDP or the local support services brokerage.

(3) An older adult or an adult with a disability eligible for or receiving case management services from the Department's Aging and People with Disabilities (APD) or Area Agency on Aging (AAA) must apply for State Plan personal care services through the local APD or AAA office.

(4) Individuals receiving benefits through the Department's Self-Sufficiency Programs (SSP) must apply for State Plan personal care services through the local APD or AAA office. APD/AAA is responsible for service assessment and for any planning and payment authorization for State Plan personal care services, if the applicant is determined eligible.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 410.020, 410.070, 410.608, 410.710, 411.116

411-034-0040 Employer-Employee Relationship *(Amended 12/23/2022)*

(1) EMPLOYER RESPONSIBILITIES. An individual or the individual's representative must demonstrate the ability to:

(a) Locate, screen, and hire a qualified HCW or employ an IHCA;

(b) Supervise and train a HCW;

(c) Schedule work, leave, and coverage;

(d) Track the hours worked and verify the authorized hours completed by a provider;

(e) Recognize, discuss, and attempt to correct any performance deficiencies with the HCW or IHCA and provide appropriate, progressive, disciplinary action as needed; and

(f) Discharge an unsatisfactory provider.

(g) Abide by federal and state laws related to employer responsibilities, including ensuring the employee is not harassed.

(2) An eligible individual exercises control as the employer and directs the provider in the provision of the services. An individual who is unable or unwilling to act as an employer may select a licensed In-Home Care Agency (IHCA) who is enrolled as a Medicaid provider.

(3) The Department makes payment for State Plan personal care services to the provider on an individual's behalf. Payment for services is not guaranteed until the Department has verified that an individual's provider meets the qualifications in OAR chapter 418, division 020 or for an in-home care agency in chapter 411, division 033.

(4) ENDING CONSUMER-EMPLOYER RELATIONSHIP. Termination and the grounds for termination of employment are determined by an individual or the individual's representative. An individual has the right to terminate an employment relationship with a provider at any time and for any reason. An individual or the individual's representative must establish an employment agreement at the time of hire. The employment agreement may include grounds for dismissal, notice of resignation, work scheduling, and absence reporting.

(5) REPRESENTATIVE.

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

(c) The individual may select another representative.

(d) 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.

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

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 410.020, 410.070, 410.608, 410.710, 411.159

411-034-0050 Provider Qualifications *(Amended 12/23/2022)*

(1) To provide personal care services to an individual who qualifies for SPPC the provider must meet the qualifications of chapter 411, division 031 or be an employee of an IHCA meeting the criteria in chapter 411, division 033.

(2) To be in alignment with the provision of services, Money Management Services (MMS) providers must have an existing Oregon Money Management Program (OMMP) contract with the Department.

(a) The provider must be in compliance with SSA representative payee requirements.

(b) All staff and volunteers must pass a background check as defined in OAR chapter 407, division 007.

(c) Providers must not solicit payment income or voluntary donations from Medicaid eligible participants.

(d) Providers who fail to meet any of the above criteria will be denied or terminated at the Department's discretion.

(3) Meals on Wheels (MOW) provider must meet qualifications in OAR chapter 411, division 040 (https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SPPD/APDRules/411-040.pdf).

(4) Long Term Care Community Nursing must meet criteria defined in OAR chapter 411, division 048.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.020, 410.070, 410.608

411-034-0055 Provider Termination *(Repealed 12/23/2022)*

411-034-0070 State Plan Personal Care Service Assessment, Authorization, and Monitoring *(Amended 12/23/2022)*

(1) PERSONAL CARE 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) A case manager must meet in person with an individual to assess the individual's ability to perform the personal care tasks listed in OAR 411-034-0020 at least once every calendar year (365 days).

(b) The individual may request that others participate in the assessment process.

(c) A case manager must consider an individual's service needs, identify the resources meeting any of the individual's needs, and determine if the individual is eligible for State Plan personal care services or other services.

(2) SERVICE PLANNING.

(a) An individual determined eligible for Personal Care services, or the individual's representative and the individual's case manager, must consider all available service options as well as assistive devices and other community-based resources to meet the service needs identified during the assessment process.

(b) The individual or the individual's representative is responsible for choosing and assisting in developing less costly service alternatives.

(c) A case manager must, in collaboration with the individual, prepare a service plan identifying the tasks for which an individual requires assistance and the number of authorized service hours per service period.

(d) When developing service plans, a case manager must consider the cost effectiveness of services that adequately meet the individual's service needs.

(A) This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual’s service needs.

(B) Those choices consist of all available service options, the utilization of assistive devices or assistive supports, natural supports, architectural modifications, and alternative service resources. Less costly alternatives may include resources not paid for by the Department.

(e) A case manager must document an individual's natural supports that currently meet some or all of the individual's personal care needs.

(f) A case manager must describe in the service plan the tasks to be performed by a qualified provider and must authorize the needed hours per service period that may be reimbursed for those services.

(g) A case manager must monitor the service plan and make adjustments as needed.

(h) Payment for State Plan Personal Care services must be prior authorized by a case manager and based on the service needs of an individual as documented in the individual's written service plan.

(3) SERVICE AUTHORIZATION

A case manager may authorize the following services if the individual has an assessed need though the Personal Care Assessment:

(a) Service plan hours for ADL and IADL needs;

(b) Mileage reimbursement;

(c) Nursing Services;

(d) Home Delivered Meals; and

(e) Money Management Services

(4) ONGOING MONITORING.

(a) When there is an indication that an individual's personal care needs have changed, a case manager must conduct an in-person re-assessment with the individual and any of the individual's natural supports if requested by the individual.

(b) Following re-assessments a case manager must review service eligibility, the cost effectiveness of the individual's service plan, and whether the services provided are meeting the identified service needs of the individual. The case manager may adjust the hours or services in the individual's service plan and must authorize a new service plan, if appropriate, based on the individual's current service needs.

(c) A case manager must provide ongoing coordination of State Plan personal care services, including authorizing changes in providers and service hours, addressing risks, and monitoring and providing information and referral to an individual when indicated.

(5) UNAUTHORIZED SERVICE SETTINGS AND PROVIDERS.

(a) The Department may not authorize services within an eligible individual’s home when --

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

(B) The services cannot be provided safely or adequately by a provider;

(C) The eligible 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 necessary safeguards cannot be provided to protect the safety, health, and welfare of the individual.

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

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 409.010, 410.020, 410.070, 410.608, 410.710

411-034-0090 Payment Limitations *(Amended 12/23/2022)*

(1) The maximum allowed hours for State Plan personal care services are limited to 270 hours per calendar year for individuals served by APD or a AAA.

(a) Individuals whose assessed service needs exceed the maximum allowed hours for State Plan personal care services in a service period may request additional hours through the exception process described in this rule. The Department Central Office may approve or deny the requests based on analysis of the individual's need and criteria for an exception.

(b) State Plan personal care service hours are authorized in accordance with an individual's service plan and may be scheduled throughout the service period to meet the service needs of the individual.

(2) Authorized LTC community nurse assessment and monitoring services are not included in the maximum hours per service period for State Plan personal care services described in section (1) of this rule.

(3) The Department does not guarantee payment for State Plan personal care services until all acceptable provider enrollment standards have been verified and both the employer and provider have been formally notified in writing that payment by the Department is authorized.

(4) In accordance with OAR 410-120-1300, all provider claims for payment must be submitted within 12 months of the date of service.

(5) Payment may not be claimed by a provider until the hours authorized for the payment period have been completed, as directed by an eligible individual or the individual's representative.

(6) Claims for Money Management may only be made by qualified money management service providers and are not included in the 270-hour limitation.

(7) Claims for Home Delivered Meals may only be made by qualified HDM providers and are not included in the 270-hour limitation.

(8) Nursing Services may only be made by licensed and enrolled long term care community nurses and the hours authorized for this service are not included in the 270 hour limitation.

Stat. Auth.: ORS 409.050, 410.070
Stats. Implemented: ORS 410.020, 410.070, 410.710, 411.159, 411.675

411-034-0091 Exceptions to Maximum Hours of Service *(Adopted 12/23/2022)*

(1) Eligibility for SPPC Exceptions to Maximum Hours of Service.

(a) If the Department determines the individual's assessed service needs will not be met within the maximum 270 annual hours as set forth in Oregon's Medicaid State Plan the individual may receive an exception to the maximum annual hours.

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

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

(B) Not medically appropriate.

(C) For assistance types not allowed by OAR 411-034-0010(6) for a particular ADL or IADL.

(D) For services not covered in the Medicaid State Plan, OAR 411-034-0020(2).

(E) For tasks not identified in OAR 411-034-0020(2).

(c) An exception is valid for the period determined by the case manager and communicated to the individual in the notice, not to exceed one calendar year.

(d) If an individual has an existing approved SPPC exception, a new request must be submitted after the annual assessment is completed 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 if section (3)(d) of this rule is not met. The case manager may supply the required documentation as outlined in section (4) of this rule.

(e) Exceptions may be reviewed at reassessments, change of care setting or living situations, or change of conditions.

(2) Responsibility for Applying for an SPPC 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 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 a SPPC exception, described in section (2) of this rule, either by completing:

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

(B) By requesting that their case manager complete the SPPC exception application form on their behalf; or

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

(b) Prior to processing an application for a SPPC exception, the case manager must discuss alternate ways to meet the individual's needs consistent with the individual's right to independence, choice, and responsibility to assist in developing the less costly plan as described in OAR 411-034-0010(15) and 411-034-0070(2)(d). Additionally, the case manager must assess if the individual is eligible for services through any other Medicaid program that provides the supports the individual needs.

(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.

(e) The CA/PS assessment must have been completed within three months before the SPPC exception request, and it must represent the individual's current condition and functioning.

(f) If the individual's application for an exception is not within the timeframe noted in subsection (e), a new assessment must be completed to document current needs. ODHS Central Office may waive this requirement in special circumstances which must be documented in the individual's application.

(g) 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.

(h) The Exception Application Request must clearly describe:

(A) The frequency per day, week or month an individual requires assistance from another person to complete personal care needs described in 411-034-0020(2). This includes personal care needs that occur regularly but on an unpredictable schedule.

(B) The duration needed to complete personal care tasks described in 411-034-0020(2).

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

(D) An explanation of why less costly options, including the maximum allowable hours, will not meet the personal care needs in 411-034-0020(2).

(E) Any additional information that may assist the reviewer in understanding the need for exceptional hours.

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

(j) 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 may issue an exception denial.

(4) Required Documentation.

(a) All Exception applications must include the SPPC Exception Application Form. The form must be complete, signed by the individual or their representative, 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 SPPC Exception Application Form, may include, but is not limited to:

(A) A SPPC Exception Calculator, which will be provided by the Department.

(B) Care provider logs detailing the performance of all personal care tasks defined in 411-034-0020(2) for one complete pay period. The log shall include the name of the personal care task, the actions required to complete the task, and the duration of the task.

(C) Any relevant medical or mental health records to support the additional time requested to complete personal care needs.

(5) Exception Decision Making Authority.

(a) ODHS Central Office shall make final decisions on exception requests that exceed the maximum allowable hours in 411-034-0090(1).

(b) Local office management may deny an application for exceptional hours if, after review, it is determined there is clear and convincing evidence that the individuals care needs do not exceed the maximum allowable hours in 411-034-0090(1).

(c) If the exception application does not meet the criteria in (5)(b) of this section, local office management must submit the exception application to ODHS CO within three business days of receipt of the completed application.

(d) ODHS CO has 30 days from the date the local office manager submits the exception request to ODHS CO.

> (A) In emergency situations that threaten the health, welfare or safety of the individual, ODHS CO will make a decision within two business days of receipt of the application. ODHS CO may elect to make a decision without all of the required documentation. Any emergent approvals end the last day of the next period after which the emergency occurred.
>
> (B) If ODHS CO determines that it needs additional information, ODHS CO 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.

(e) The individual, or their representative, or case manager must provide the requested information to ODHS CO within 14 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) ODHS CO has 14 days from the date of receipt of the additional information to make a determination.
>
> (B) If the individual fails to provide the requested information within the required timeframe, ODHS CO will complete the review based on the documentation in its possession. ODHS

CO has 14 days from the date of the individual's deadline for additional information to complete its 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 a new SPPC exception, with a new effective date based on the date the new information was provided.

(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 ODHS CO issue a revised decision. ODHS CO will review the request and make a determination within 3 business days regarding good cause.

(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.

(f) For each Exception Application:

(A) If the Department determines that the documentation supports the requested additional hours over the maximum for the specific personal care needs, 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 "partially denied" and only those additional hours supported by the documentation will be granted.

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

(D) If ODHS denies any portion of an Exception Application the individual, or their representative, may request a hearing.

(6) Exception Application Reviews and Decision Making

(a) All exception applications must be for services that meet the definitions of personal care services and associated assistance types defined in 411-034-0020.

(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 Medicaid approved provider has been authorized to work. If these do not occur on the same date, the later date is the effective date.

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

(A) SPPC Assessment Synopsis;

(B) CA/PS Assessment Comments;

(C) Treatments that may drive care needs;

(D) Diagnosis that may drive care needs;

(E) Medical documentation supporting the way services are being provided to meet the personal care needs of the individual;

(F) Medical documentation, including those from the Long-Term Care Community Nurse or Behavior Support Specialists, that shows that the allowable hours are not meeting the individual's personal care needs;

(G) The change or cause driving increased duration and frequency; and

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

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

(A) The frequency per day, week or month an individual requires assistance from another person to complete personal care needs described in 411-034-0020(2). This includes personal care needs that occur regularly but on an unpredictable schedule.

(B) The duration needed to complete personal care tasks described in 411-034-0020(2).

(C) The number of Medicaid approved providers required to perform assessed personal care service needs.

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

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

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

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

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

(A) Natural supports as defined in OAR 411-034-0010(29);

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

(C) Emergency Response Systems;

(D) Home and Environmental Modifications;

(E) 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 requested hours if:

(A) The requested hours are not for personal care needs defined in 411-034-0020(2); or

(B) The information regarding how services are provided is determined to be not medically appropriate or necessary.

(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 personal care services, the number of hours requested, compared to maximum hours and total approved hours.

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

(E) The duration of the exception.

(F) Hearing rights and what to do if the individual does not agree with the decision.

(8) EXCEPTION DECISION AUTHORITY. The final decision may be made by the local office or ODHS CO when the exception application does not exceed the total 270 annual hour maximum defined in OAR 411-034-0090(1).

Stat. Auth.: ORS 409.050, 410.070
Stats Implemented: ORS 410.020, 410.070, 410.608, 410.710, 411.116