

Secretary of State  
Certificate and Order for Filing  
**PERMANENT ADMINISTRATIVE RULES**

I certify that the attached copies are true, full and correct copies of the PERMANENT Rule(s) adopted on Upon filing, by the

Department of Human Services, Aging and People with Disabilities and Developmental Disabilities 411  
Agency and Division Administrative Rules Chapter Number  
Christina Hartman (503) 945-6398  
Rules Coordinator Telephone  
500 Summer St. NE, E-10, Salem, OR 97301-1074  
Address

To become effective 12/15/2013 Rulemaking Notice was published in the November 2013 Oregon Bulletin.

**RULE CAPTION**

Medicaid Home and Community-Based Services

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

**RULEMAKING ACTION**

Secure approval of new rule numbers with the Administrative Rules Unit prior to filing.

**ADOPT:**

**AMEND:**  
411-001-0510, 411-030-0070, 411-030-0100, 411-040-0000, 411-045-0010, 411-045-0050, 411-048-0150, 411-048-0160, 411-048-0170, 411-065-0000, 411-070-0033

**REPEAL:**

411-001-0510(T), 411-030-0070(T), 411-030-0100(T), 411-040-0000(T), 411-045-0010(T), 411-045-0050(T), 411-048-0150(T), 411-048-0160(T), 411-048-0170(T), 411-065-0000(T), 411-070-0033(T)

**RENUMBER:**

**AMEND AND RENUMBER:**

**Statutory Authority:**

ORS 410.070

**Other Authority:**

**Statutes Implemented:**

ORS 410.070

**RULE SUMMARY**

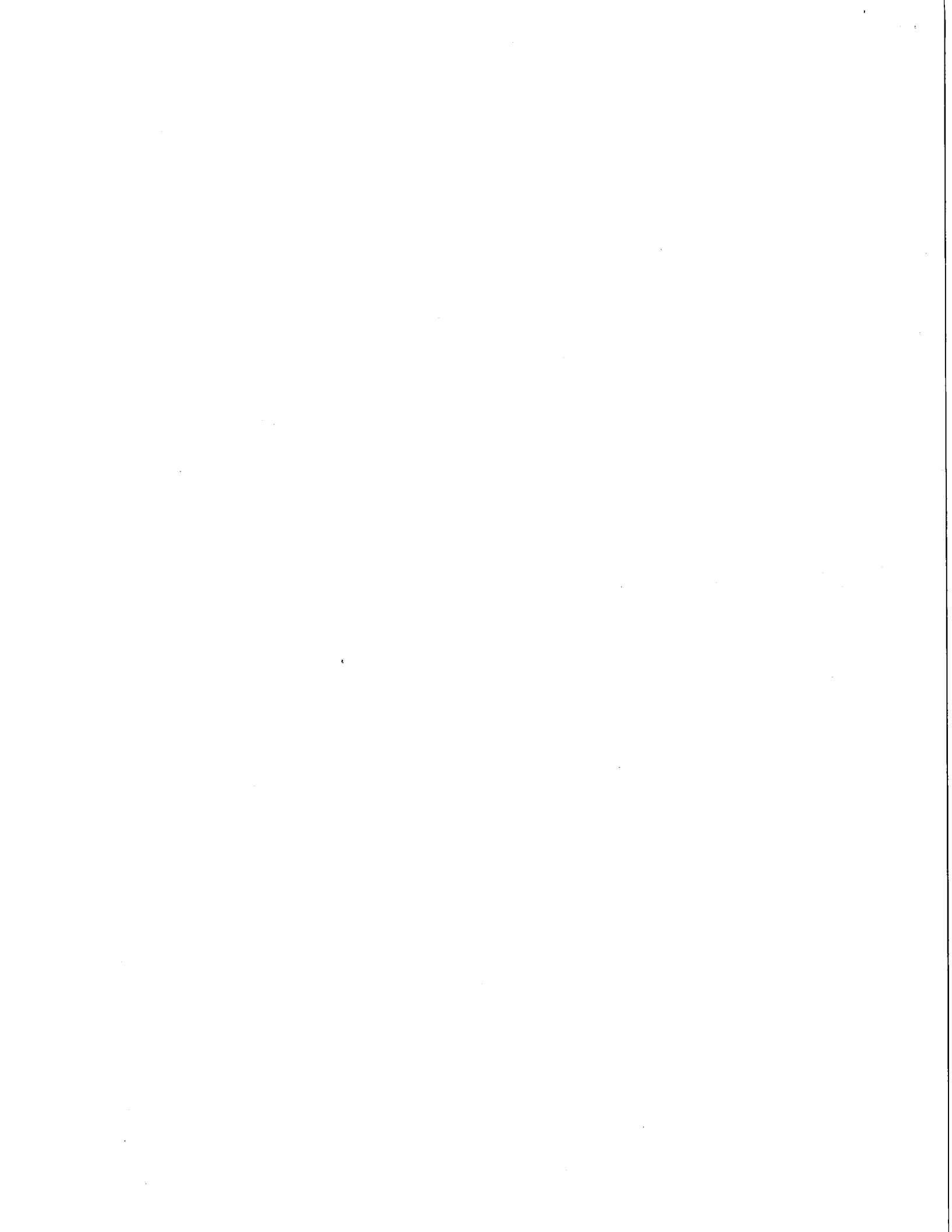
The Department of Human Services is permanently amending the rules for Aging and People with Disabilities in OAR chapter 411 to make permanent the changes adopted by temporary rule that became effective on July 1, 2013 as a result of a change in Medicaid funding for community-based services.

**FILED**  
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Rules Coordinator Name

christina.hartman@state.or.us  
Email Address

OPD 11-2013



**Authorization Page**

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**PERMANENT ADMINISTRATIVE RULES**

Department of Human Services, Aging and People with  
Disabilities and Developmental Disabilities

411

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Agency and Division

Administrative Rules Chapter Number

Christina Hartman

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Rules Coordinator

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500 Summer St. NE, E-10, Salem, OR 97301-1074

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Telephone

Upon filing.

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Adopted on

12/15/2013

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Effective date

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Medicaid Home and Community-Based Services

Not more than 15 words

**RULEMAKING ACTION**

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**RENUMBER:**

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**AMEND & RENUMBER:**

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Stat. Auth.: ORS 410.070

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Other Auth.:

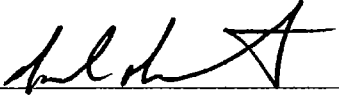
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Stats. Implemented: ORS 410.070

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**RULE SUMMARY**

The Department of Human Services is permanently amending the rules for Aging and People with Disabilities in OAR chapter 411 to make permanent the changes adopted by temporary rule that became effective on July 1, 2013 as a result of a change in Medicaid funding for community-based services.



Michael McBurnick

12/11/13

Authorized Signer

Printed Name

Date

Authorization Page replaces the ink signature on paper filings. Have your authorized signer sign and date, then scan and attach it to your filing. You must complete this step before submitting your Permanent and Temporary filings.

**DIVISION 1  
CONTESTED CASE HEARINGS**

**411-001-0510**

**Lay Representation in Contested Case Hearings**

- (1) Subject to the approval of the Attorney General, an officer or employee of the Department of Human Services (Department) is authorized to appear on behalf of the Department in the following types of hearings conducted by the Office of Administrative Hearings:
- (a) Eligibility for services available through a waiver or state plan administered by the Department's Aging and People with Disabilities (APD) or Developmental Disabilities (DD), including but not limited to the level or amount of benefits, and effective date;
  - (b) Eligibility for medical benefits, the level and amount of benefits, and effective date;
  - (c) Overpayments related to waived or state plan service benefits or medical benefits;
  - (d) Suspension, reduction, or denial of medical assistance services, prior authorizations, or medical management decisions; and
  - (e) Consumer-employed provider matters, including but not limited to provider enrollment or denial of enrollment, overpayment determinations, audits, and sanctions.
- (2) A Department officer or employee acting as the Department's representative may not make legal argument on behalf of the Department.
- (a) "Legal argument" includes arguments on:
    - (A) The jurisdiction of the Department to hear the contested case;
    - (B) The constitutionality of a statute or rule or the application of a constitutional requirement to the Department; and
    - (C) The application of court precedent to the facts of the particular contested case proceeding.
  - (b) "Legal argument" does not include presentation of motions, evidence, examination and cross-examination of witnesses, or presentation of factual arguments or arguments on:
    - (A) The application of the statutes or rules to the facts in the contested case;
    - (B) Comparison of prior actions of the Department in handling similar situations;
    - (C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case;
    - (D) The admissibility of evidence; and
    - (E) The correctness of procedures being followed in the contested case hearing.
- (3) When an officer or employee appears on behalf of the Department, the administrative law judge shall advise the Department's representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection.
- (4) If the administrative law judge determines that statements or objections made by the Department representative appearing under section (1) of this rule involve legal argument as defined in this rule, the administrative law judge shall provide reasonable opportunity for the Department representative to consult the Attorney General and permit the Attorney General to present argument at the hearing or to file written legal argument within a reasonable time after conclusion of the hearing.
- (5) The Department is subject to the Code of Conduct for Non-Attorney Representatives at Administrative Hearings, which is maintained by the Oregon Department of Justice and available at <http://www.doj.state.or.us>. A Department representative appearing under section (1) of this rule must read and be familiar with the Code of Conduct for Non-Attorney Representatives at Administrative Hearings.
- (6) When a Department officer or employee represents the Department in a contested case hearing, requests for admission and written interrogatories are not permitted.

Stat. Auth: ORS 409.050

Stats Implemented: ORS 183.452 & 409.010

**DIVISION 30  
IN-HOME SERVICES**

**411-030-0070**

**Maximum Hours of Service**

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

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

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

**(2) MAXIMUM MONTHLY HOURS FOR ADL.**

(a) The planning process uses the following limitations for time allotments for ADL tasks. Hours authorized must be based on the service needs of an individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

**(A) Eating:**

- (i) Minimal assistance, 5 hours;
- (ii) Substantial assistance, 20 hours;
- (iii) Full assistance, 30 hours.

**(B) Dressing/Grooming:**

- (i) Minimal assistance, 5 hours;
- (ii) Substantial assistance, 15 hours;
- (iii) Full assistance, 20 hours.

**(C) Bathing and Personal Hygiene:**

- (i) Minimal assistance, 10 hours;
- (ii) Substantial assistance, 15 hours;
- (iii) Full assistance, 25 hours.

**(D) Mobility:**

- (i) Minimal assistance, 10 hours;
- (ii) Substantial assistance, 15 hours;
- (iii) Full assistance, 25 hours.

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

- (i) Minimal assistance, 10 hours;
- (ii) Substantial assistance, 20 hours;
- (iii) Full assistance, 25 hours.

**(F) Cognition/Behavior:**

- (i) Minimal assistance, 5 hours;
- (ii) Substantial assistance, 10 hours;
- (iii) Full assistance, 20 hours.

(b) 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 that activity of daily living as determined by a service assessment applying the parameters in OAR 411-015-0006.

(c) For households with two or more eligible individuals, each individual's ADL service needs must be considered separately. In accordance with section (3)(c) of this rule, authorization of IADL hours is limited for each additional individual in the home.

(d) Hours authorized for ADL are paid at hourly rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for ADLs paid at the hourly rates. Participants of the Independent Choices Program may determine their own employee provider pay rates.

**(3) MAXIMUM MONTHLY HOURS FOR IADL.**

(a) The planning process uses the following limitations for time allotments for IADL tasks. Hours authorized must be based on the service needs of an individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

**(A) Medication and Oxygen Management:**

- (i) Minimal assistance, 2 hours;
- (ii) Substantial assistance, 4 hours;
- (iii) Full assistance, 6 hours.

**(B) Transportation or Escort Assistance:**

- (i) Minimal assistance, 2 hours;
- (ii) Substantial assistance, 3 hours;
- (iii) Full assistance, 5 hours.

**(C) Meal Preparation:**

(i) Minimal assistance prior to January 1, 2012:

- (I) Breakfast, 4 hours;
- (II) Lunch, 4 hours;
- (III) Supper, 8 hours.

(ii) Minimal assistance effective January 1, 2012:

(I) Breakfast, 3 hours;

(II) Lunch, 3 hours;

(III) Supper, 7 hours.

(iii) Substantial assistance prior to January 1, 2012:

(I) Breakfast, 8 hours;

(II) Lunch, 8 hours;

(III) Supper, 16 hours.

(iv) Substantial assistance effective January 1, 2012:

(I) Breakfast, 7 hours;

(II) Lunch, 7 hours;

(III) Supper, 14 hours.

(v) Full assistance prior to January 1, 2012:

(I) Breakfast, 12 hours;

(II) Lunch, 12 hours;

(III) Supper, 24 hours.

(vi) Full assistance effective January 1, 2012:

(I) Breakfast, 10 hours;

(II) Lunch, 10 hours;

(III) Supper, 21 hours.

(D) Shopping:

(i) Minimal assistance, 2 hours;

(ii) Substantial assistance, 4 hours;

(iii) Full assistance, 6 hours.

(E) Housecleaning:

(i) Minimal assistance:

(I) Prior to January 1, 2012, 5 hours.

(II) Effective January 1, 2012, 4 hours.

(ii) Substantial assistance:

(I) Prior to January 1, 2012, 10 hours.

(II) Effective January 1, 2012, 9 hours.

(iii) Full assistance:

(I) Prior to January 1, 2012, 20 hours.

(II) Effective January 1, 2012, 18 hours.

(b) Rates are paid in accordance with the rate schedule.

(A) When a live-in employee is present, IADL hours may be paid at less than minimum wage according to the Fair Labor Standards Act.

(B) The Independent Choices Program cash benefit is based on the hours authorized for IADL tasks paid at the hourly rates. Participants of the Independent Choices Program may determine their own employee provider pay rates.

(c) When two or more individuals eligible for IADL task hours live in the same household, the assessed IADL need of each individual must be calculated. Payment is made for the highest of the allotments and a total of four additional IADL hours per month 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.

(4) TWENTY-FOUR HOUR AVAILABILITY.

(a) Payment for 24-hour availability is authorized only when an individual employs a live-in homecare worker or Independent Choices Program employee provider and requires 24-hour availability due to the following:

(A) The individual requires assistance with ADL or IADL tasks at unpredictable times throughout most 24-hour periods; and

(B) The individual requires minimal, substantial, or full assistance with ambulation and requires assistance with transfer (as defined in OAR 411-015-0006); or

(C) The individual requires full assistance in transfer or elimination (as defined in OAR 411-015-0006); or

- (D) The individual requires full assist in at least three of the eight components of cognition/behavior (as defined in OAR 411-015-0006).
- (b) The number of hours allowed per month shall have the following maximums. Hours authorized are based on the service needs of an individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).
- (A) Minimal assistance -- 60 hours. Minimal assistance hours may be authorized when an individual requires one of these assessed needs as defined in OAR 411-015-0006:
- (i) Full assist in cognition; or
  - (ii) Full assist in toileting or bowel or bladder.
- (B) Substantial assistance -- 110 hours. Substantial assistance hours may be authorized when an individual requires these assessed needs as defined in OAR 411-015-0006:
- (i) Assist in transfer; and
  - (ii) Assist in ambulation; and
  - (iii) Full assist in cognition; or
  - (iv) Full assist in toileting or bowel or bladder.
- (C) Full assistance -- 159 hours. Full assistance hours may be authorized when:
- (i) The authorized provider is unable to get at least five continuous hours of sleep in an eight hour period during a 24-hour work period; and
  - (ii) The eligible individual requires the following assessed needs as defined in OAR 411-015-0006:
    - (I) Full assist in transfer; and
    - (II) Assist in mobility; or
    - (III) Full assist in toileting or bowel or bladder; or
    - (IV) Full assist in cognition.
- (c) Service plans that include full-time live-in homecare workers or Independent Choices Program employee providers must include a minimum of 60 hours per month of 24-hour availability.
- (A) When a live-in homecare worker or Independent Choices Program employee provider is employed less than full time, the hours must be pro-rated.
- (B) Full-time means the live-in homecare worker is providing services to the consumer-employer seven days per week throughout a calendar month.
- (d) Rates for 24-hour availability are in accordance with the rate schedule and paid at less than minimum wage according to the Fair Labor Standards Act and ORS 653.020.
- (e) Twenty-four hour availability assumes the homecare worker is available to address the service needs of an individual as they arise throughout a 24-hour period. A homecare worker who engages in employment outside the eligible individual's home or building during the work periods the homecare worker is on duty, is not considered available to meet the service needs of the individual.
- (5) 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.
- (6) **AUTHORIZED HOURS ARE SUBJECT TO THE AVAILABILITY OF FUNDS.** 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) to reduce an individual's reliance on paid in-home services hours.
- (7) 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.
- (8) Payment by the Department for Medicaid home and community-based services are only made for the tasks described in this rule as ADL, IADL tasks, and 24-hour availability. Services must be authorized to meet the needs of an eligible individual and may not be provided to benefit an entire household.
- (9) **EXCEPTIONS TO MAXIMUM HOURS OF SERVICE.**
- (a) To meet an extraordinary ADL service need that has been documented, the hours authorized for ADL may exceed the full assistance hours (described in section (2) of this rule) as long as the total number of ADL hours in the service plan does not exceed 145 hours per month.
  - (b) Monthly service payments that exceed 145 ADL hours per month may be approved by the Department when the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050 is met.
  - (c) Monthly service plans that exceed 145 ADL, 76 IADL, and 159 24-hour availability hours per month for a live-in homecare worker or Independent Choices Program employee provider, or that exceed the equivalent monthly

service payment for an hourly services plan, may be approved by the Department when the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050 is met.

(d) As long as the total number of IADL task hours in the service plan does not exceed 76 hours per month and the service need is documented, the hours authorized for IADL tasks may exceed the hours for full assistance (as described in section (3) of this rule) for the following tasks and circumstances:

(A) Housekeeping based on medical need (such as immune deficiency);

(B) Short-term extraordinary housekeeping services necessary to reverse unsanitary conditions that jeopardize the health of an individual; or

(C) Extraordinary IADL needs in medication management or service-related transportation.

(e) Monthly service plans that exceed 76 hours per month in IADL tasks may be approved by the Department when an individual meets the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050.

Stat. Auth.: ORS 409.050, 410.070 & 410.090

Stats. Implemented: ORS 410.010, 410.020 & 410.070

#### **411-030-0100**

##### **Independent Choices Program**

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

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

(b) The Department enters names on the waiting list according to the date submitted by the Department/AAA office.

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

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

(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;

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

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

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

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

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

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

(c) If a participant is unable to manage 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 funds 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. If the ICP enrollment cap has been reached, participants who were disenrolled are added to the waiting list.

(a) VOLUNTARY DISENROLLMENT. Participants or representatives must provide notice to the Department of intent to discontinue participation in the ICP. The participant or the representative must meet with the Department to

reconcile remaining ICP cash payment either within 30 days of the date of disenrollment or before the termination date, whichever is sooner.

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

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

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

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

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

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

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

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

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

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

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

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

(J) Failure to select a representative within 30 days if a participant needs a representative and does not have one.

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

(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, IADL, and twenty-four hour availability 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, the IADL task hours, and the twenty-four hour availability 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; and

(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.

(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 must be initially approved by a Department/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 Medicaid or the Supplemental Nutrition Assistance Program (SNAP) that substitute for personal assistance and allow for greater independence.

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

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

(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/AAA case manager must complete a service budget review to assure financial accountability and review service budget amendments.

(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

**DIVISION 40  
MEDICAID FUNDED HOME DELIVERED MEALS**

**411-040-0000**

**Medicaid Funded Home Delivered Meals**

(1) Home delivered meals, exclusive of those funded through the Older Americans Act or Oregon Project Independence, constitute a service that is provided as part of Medicaid home and community-based services to assist an individual to remain in his or her own home.

(2) Payment for meals delivered to an individual at his or her home may be provided when other plans do not appear feasible and home delivered meals are determined by the Department's local unit to be more appropriate for the individual's needs than nursing facility services. The cost for these meals is calculated into the individual's service plan in conjunction with in-home services provided by a consumer-employed provider or a home care agency.

(3) All requests for Medicaid-funded home delivered meals must be referred to the Department's local unit.

(4) The Department/AAA case manager is responsible for establishing, authorizing, purchasing, and monitoring a plan for home-delivered meals.

(5) Individuals who are required to make a monthly payment under OAR 461-185-0050 in order to remain eligible for Medicaid home and community-based services must have the home-delivered meal costs calculated in conjunction with the in-home service provider costs.

(a) To remain eligible for Medicaid home and community-based services, pay-in individuals are responsible for payment of authorized home-delivered meals received up to their specified monthly pay-in amount. Individual payments due for meal services are to be included as part of the monthly sum sent to the Department's pay-in unit rather than making any direct payments to the meal provider.

(b) The Department is responsible for direct payments made to providers for all authorized home-delivered meals to individuals receiving Medicaid home and community-based services. Direct payment from the Department includes meals paid through the individual's monthly pay-in and for meals that exceed the individual's total monthly liability.

(6) For individuals whose meals are delivered through an Older Americans Act meal service program, which also contracts as a Medicaid home delivered meals provider:

(a) Individuals receiving home-delivered meals authorized and paid for by the Department must be officially informed by the case manager that there is no obligation to make any voluntary or suggested donation for this service. However, if the individual chooses to make a voluntary donation, there is no restriction from doing so.

(b) If the individual has a monthly payment to the Department under OAR 461-185-0050 in order to remain eligible for services, the individual must meet the criteria in both subsections (5) and (6)(a) of this rule.

(c) An individual who meets the criteria in subsections (2) or (5) of this rule and is age 65 or older, may choose to receive meals through the Older Americans Act (OAA) meal service program and may make voluntary donations. For individuals required to make a monthly payment under OAR 461-185-0050, these donations may not be credited toward the pay-in liability. In turn, OAA meal programs are not mandated to provide home-delivered meals to individuals age 65 and older receiving Medicaid home and community-based services unless the agency is a Medicaid-contracted meal provider and the meals are authorized and paid for by the Department.

Stat. Auth.: ORS 410.070, 411.060 & 411.070

Stats. Implemented: ORS 410.070

## DIVISION 45

### PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

#### 411-045-0010

##### Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 045:

(1) Administrative Hearing -- A hearing related to a denial, reduction, or termination of benefits that is held when requested by the PACE participant or his or her representative. A hearing may also be held when requested by a PACE participant who believes a claim for services was not acted upon with reasonable promptness or believes the payor took an action erroneously.

(2) Advance Directive -- A process that allows a person to have another person make health care decisions when he or she is unable to make the decision and tell a doctor what life sustaining measures to take if he or she is near death.

(3) Aging and People with Disabilities Division (APD) -- A division within the Department that is the designated State Unit on Aging (SUA) that also administers Medicaid's long-term care program. APD is responsible for nursing facility and Medicaid home and community-based services for eligible older adults and individuals with disabilities. APD includes local offices and the AAAs who have contracted to perform specific functions of the licensing and enrollment processes.

(4) Alternate Service Settings -- Residential 24-hour care facilities that include, but are not limited to, residential care facilities, assisted living facilities, adult foster homes, and nursing facilities.

(5) Americans with Disabilities Act (ADA) -- Federal law defining the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service delivery, and facility accessibility.

(6) Ancillary Services -- Those medical services that are medically appropriate to support a covered service under the PACE benefit package. A list of ancillary services and limitations is specified in DMAP's Ancillary Services Criteria Guide.

(7) Appeal -- A PACE participant's action taken with respect to any instance where the PACE program reduces, terminates, or denies a covered service.

(8) Area Agency on Aging (AAA) -- An established public agency within a planning and service area designated under Section 305 of the Older American's Act that has responsibility for local administration of Department programs. AAAs contract with the Department to perform specific activities in relation to PACE programs including processing of applications for Medicaid and determining the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services.

(9) Assessment -- The determination of a participant's need for covered services. An assessment involves the collection and evaluation of data by each of the members of the Interdisciplinary Team pertinent to the participant's

health history and current problems obtained through interview, observation, and record review. The Assessment concludes with one of the following:

- (a) Documentation of a diagnosis providing the clinical basis for a written care plan; or
  - (b) A written statement that the participant is not in need of covered services for a particular condition.
- (10) Automated Information System (AIS) -- A computer system that provides information on the current eligibility status for participants under the Medical Assistance Program.
- (11) Care Plan -- Service plan as defined in this rule.
- (12) Centers for Medicare and Medicaid Services (CMS) -- Formerly known as the Health Care Financing Administration (HCFA). The federal agency under the Department of Health and Human Services that is responsible for approving the PACE program and joining the state in signing an agreement with the PACE program once it has been approved as a provider under 42 CFR Part 460.
- (13) Clinical Record -- The clinical record includes, but is not limited to, the medical, social services, dental, and mental health records of a PACE participant. Clinical records include the Interdisciplinary Team's records, hospital records, and grievance and disenrollment records.
- (14) Comfort Care -- The provision of medical services or items that give comfort or pain relief to a participant who has a terminal illness. Comfort care includes the combination of medical and related services designed to make it possible for a participant with terminal illness to die with dignity, respect, and with as much comfort as is possible given the nature of the illness. Comfort care includes but is not limited to, pain medication, palliative services, and hospice care including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable comfort care is provided consistent with Section 4751 OBRA 1990 -- Patient Self-Determination Act and ORS 127.505-127.660 and 127.800-127.897 relating to health care decisions. Comfort care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness and intended to prolong life.
- (15) Community Standard -- Typical expectations for access to the health care delivery system in the PACE participant's community of residence. The Department requires that the health care delivery system available to PACE participants take into consideration the community standard and be adequate to meet the needs of PACE participants except where the community standard is less than sufficient to ensure quality of care.
- (16) Covered Services -- Those diagnoses, treatments, and services listed in OAR 410-141-0520. In addition, all services that are to be covered by Medicare are covered services even if the services fall below the currently funded line for the Oregon Health Plan. Covered services also include those services listed in 42 CFR Sections 460.92 and 460.94.
- (17) Dentally Appropriate -- Services that are required for prevention, diagnosis, or treatment of a dental condition and that are:
- (a) Consistent with the symptoms of a dental condition or treatment of a dental condition;
  - (b) Appropriate with regard to standards of good dental practice and generally recognized by the relevant scientific community and professional standards of care as effective;
  - (c) Not solely for the convenience of the PACE participant or a provider of the service; and
  - (d) The most cost effective of the alternative levels of dental services that may be safely provided to a PACE participant.
- (18) Dental Emergency Services -- Dental services provided for severe pain, bleeding, unusual swelling of the face or gums, or an avulsed tooth.
- (19) Department -- The Department of Human Services.
- (20) DHS -- Department of Human Services (DHS).
- (21) Disenrollment -- The act of discharging a PACE participant from a PACE program. After the effective date of disenrollment a PACE participant is no longer authorized to obtain covered services from the PACE program.
- (22) Emergency Services -- The health care and services provided for diagnosis and treatment of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, may reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- (23) Enrollment -- A process for the PACE program. A PACE participant's enrollment with a PACE program indicates that the PACE participant obtains from, or is referred by, the PACE program for all covered services.
- (24) Grievance -- A PACE participant's or the participant's representative's clear expression of dissatisfaction with the PACE program that addresses issues that are part of the PACE program's contractual responsibility. The

expression states the reason for the dissatisfaction and may be in whatever form of communication or language that is used by the participant or the participant's representative.

(25) Health Management Unit (HMU) -- The DMAP unit responsible for adjustments to enrollments and retroactive disenrollments.

(26) Interdisciplinary Team (IDT) -- PACE staff and PACE subcontractors with current and appropriate licensure, certification, or accreditation who are responsible for assessment and development of the PACE participant's care plan. An IDT may conduct assessments of PACE participants and provide services to PACE participants within their scope of practice, state licensure, or certification. An IDT includes at least one representative from each of the following groups:

(a) Medical Doctor, Osteopathic Physician, Nurse Practitioner, or Physician's Assistant;

(b) Registered Nurse or a Licensed Practical Nurse supervised by a Registered Nurse;

(c) Social Worker with a Master's degree or a Social Worker with a Bachelor degree who is supervised by a Master's level Social Worker;

(d) Occupational Therapist or a Certified Occupational Therapy Assistant supervised by an Occupational Therapist;

(e) Recreational Therapist or an Activity Coordinator with two years experience;

(f) Physical Therapist or a Physical Therapy Assistant supervised by a Physical Therapist;

(g) Dietician and Pharmacist as indicated; and

(h) In addition to the positions listed above in subsections (a) to (g) of this section, the IDT includes the PACE Center Manager, the Home Care Coordinator, Personal Care Attendant, and the Driver or Transportation Coordinator.

(27) Medicaid -- A federal and state funded portion of the Medical Assistance Program established by Title XIX of the Social Security Act, as amended and administered in Oregon by the Department of Human Services.

(28) Medically Appropriate -- Services and medical supplies required for prevention, diagnosis, or treatment of a health condition that encompasses physical or mental conditions, or injuries, and that are:

(a) Consistent with the symptoms of a health condition or treatment of a health condition;

(b) Appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective;

(c) Not solely for the convenience of a PACE participant or a provider of the service or medical supplies; and

(d) The most cost effective of the alternative levels of medical services or medical supplies that may be safely provided to a PACE participant in the PACE program's judgment.

(29) Medicare -- The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

(30) Non-Covered Services -- Services or items the PACE program is not responsible for providing or paying for.

(31) Non-Participating Provider -- A provider who does not have a contractual relationship with the PACE program, i.e., is not on their panel of providers.

(32) Division of Medical Assistance Programs (DMAP) -- The division of the Oregon Health Authority responsible for coordinating medical assistance programs. DMAP writes and administers the state Medicaid rules for medical services, contracts with providers, maintains records of participant eligibility and processes, and pays DMAP providers and contractors such as PACE.

(33) Oregon Health Plan (OHP) -- The Medicaid demonstration project that expands Medicaid eligibility. The Oregon Health Plan relies substantially upon a prioritization of health services and managed care to achieve the policy objectives of access, cost containment, efficacy, and cost effectiveness in the allocation of health resources.

(34) PACE -- The Program of all Inclusive Care for the Elderly (PACE) is a managed care entity that provides medical, dental, mental health, social services, transportation, and long-term care services to persons age 55 and older on a prepaid capitated basis in accordance with a signed agreement with the Department and CMS.

(35) PACE Participant -- An individual who meets the Department criteria for nursing facility care and is enrolled in the PACE program. These individuals are eligible under the following categories:

(a) AB/AD (Assistance to Blind and Disabled) with Medicare -- Individuals with concurrent Medicare eligibility with income under Medicaid eligibility;

(b) AB/AD without Medicare -- Individuals without Medicare with income under Medicaid eligibility;

(c) OAA (Old Age Assistance) with Medicare -- Individuals with concurrent Medicare Part A or Medicare Parts A and B eligibility with income under Medicaid eligibility;

(d) OAA without Medicare -- Individuals without Medicare with income under Medicaid eligibility; or

(e) Private -- Individuals with or without Medicare with incomes over Medicaid eligibility.

- (36) Participating Provider -- An individual, facility, corporate entity, or other organization that supplies medical, dental, or mental health services or items who have agreed to provide those services or items and to bill in accordance with a signed agreement with a PACE program.
- (37) Preventive Services -- Those services as defined under Expanded Definition of Preventive Services in OAR 410-141-0480 and 410-141-0520.
- (38) Primary Care Provider (PCP) -- A medical practitioner who has responsibility for supervising and coordinating initial and primary care within his or her scope of practice for PACE participants. Primary Care Providers initiate referrals for care outside their scope of practice that may include consultations and specialist care, and assure the continuity of medically or dentally appropriate care.
- (39) Quality Improvement -- Quality improvement is the effort to improve the level of performance of a key process or processes in health and long term care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance, and implements new and better methods for the processes. Quality Improvement includes the goals of quality assurance, quality control, quality planning, and quality management in health care. Quality of care reflects the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and is consistent with current professional knowledge.
- (40) Representative -- A person who can assist the PACE participant in making administrative related decisions such as, but not limited to, completing an enrollment application, filing grievances, and requesting disenrollment. A representative may be, in the following order of priority, a person who is designated as the PACE participant's health care representative, a court-appointed guardian, a spouse, other family member as designated by the PACE participant, the Individual Service Plan Team (for individuals with intellectual or developmental disabilities), or a Department/AAA case manager or other Department designee. This definition does not apply to health care decisions unless the representative has legal authority to make such decisions.
- (41) Seniors and People with Disabilities - Aging and People with Disabilities as defined in this rule.
- (42) Service Area -- The geographic area defined by Federal Information Processing Standards (FIPS) codes, or other criteria determined by the Department, in which the PACE program has agreed to provide services under the Oregon PACE program regulations and the Federal PACE regulations 42 CFR Part 460. The service area is defined in the PACE contract with the Department.
- (43) Service Plan -- An individualized, written plan that addresses all relevant aspects of a participant's health and socialization needs that is developed by the Interdisciplinary Team with the involvement of the participant and the participant's representative. A service plan is based on the findings of the participant's assessments and defines specific service and treatment goals and objectives, proposed interventions, and the measurable outcomes to be achieved. A service plan is reviewed at least every four months or as indicated by a change in the participant's condition.
- (44) Triage -- Evaluations conducted to determine whether or not an emergency condition exists, and to direct the DMAP member to the most appropriate setting for medically appropriate care.
- (45) Urgent Care Services -- Covered services required to prevent a serious deterioration of a PACE participant's health that results from an unforeseen illness or an injury and for dental services necessary to treat such conditions as lost fillings or crowns. Services that may be foreseen by the individual are not considered urgent services.
- (46) Valid Claim --
- (a) An invoice received by the PACE program for payment of covered health care services rendered to an eligible PACE participant that:
    - (A) May be processed without obtaining additional information from the provider of the service or from a third party; and
    - (B) Has been received within the time limitations prescribed in these rules.
  - (b) A "valid claim" is synonymous with the federal definition of a "clean claim" as defined in 42 CFR 447.45(b).
- (47) Valid Pre-Authorization -- A request, received by the PACE program for approval of covered health care services provided by a non-participating provider to an eligible individual, that may be processed without obtaining additional information from the provider of the service or from a third party.

Stat. Auth.: ORS 410.090

Stats. Implemented: ORS 410.070

#### **411-045-0050**

##### **Enrollment**

(1) ELIGIBILITY: To be eligible to enroll in a PACE program a person must:

- (a) Reside in the PACE program's approved service area upon enrollment;

- (b) Be 55 years of age or older;
  - (c) Be able to be maintained in a community-based setting at the time of enrollment without jeopardizing his or her health or safety or the health and safety of others;
  - (d) Be determined by the local Department/AAA agency to need the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services in accordance with the rules in OAR chapter 411, division 015 (Long-Term Care Service Priorities for Individuals Served);
  - (e) Be Medicaid eligible or be willing to pay private fees; and
  - (f) Be willing to abide by the provision that requires enrollees to receive all health and long term care services exclusively from the PACE program and its contracted or referred providers.
- (2) The criteria for determining that an individual is unable to live safely in the community and thereby may be denied enrollment is as follows:
- (a) The individual demonstrates imminent danger to self or others in accordance with the definition in OAR 411-015-0005;
  - (b) There is evidence in the individual's clinical record that shows he or she has been repeatedly placed in appropriate care settings and, despite medically appropriate treatment, placement has resulted in frequent hospitalizations or failed placements;
  - (c) At the time of application, the individual is determined to be eligible for enhanced care services or long term care at Oregon State Hospital by either the enhanced care Services Coordinator or the OSH Gero-Psychiatric Outreach Team;
  - (d) At the time of application, the individual has a physician documented condition that meets the criteria for Medicare skilled care and does not appear to be able to be discharged to the community within the next 30 days; or
  - (e) At the time of application, the applicant lives in his or her own home and wishes to remain there but requires 24-hour care to remain safely in their home.
- (3) If either the PACE program or the local Department/AAA case manager has concerns about the safety of a potential enrollee, a case conference may be convened to review the case with outside consultants as needed for further evaluation.
- (4) **ENROLLMENT/SCREENING AND INTAKE:**
- (a) Department/AAA staff processes an application for Medicaid services and determines the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services. Department/AAA staff follows the appropriate PACE enrollment protocols as outlined in the Department/AAA Policy Manuals.
  - (b) Department/AAA staff conducts initial screening and intake, including providing assistance in completing the application and obtaining relevant information.
  - (c) The Department provides for the calculation of any applicable spend-down liability and for post-eligibility treatment of income for Medicaid participants in the same manner as the Department treats spend-down liability and post-eligibility income for individuals receiving Medicaid home and community-based services (OAR 461-160-0620).
  - (d) The Department/AAA staff forwards intake information of potential enrollees to the PACE program staff who assesses the applicant's appropriateness for enrollment in the PACE program in accordance with these rules and the requirements of 42 CFR 460.152. Potential enrollees may be denied enrollment by the PACE program if the PACE program determines the individual is not able to be maintained in a community-based setting without jeopardizing his or her health or safety or the health and safety of others.
  - (e) If the potential enrollee or his or her representative is in disagreement with the PACE program's decision not to enroll the person, he or she may file an appeal with the Department.
  - (f) All letters to applicants regarding denial of enrollment by the PACE program must include the reason for the denial and the applicants appeal rights. This letter along with documentation of pertinent information related to the decision must be forwarded to the Department for review.

Stat. Auth.: ORS 410.090

Stats. Implemented: ORS 410.070

**DIVISION 48  
LONG TERM CARE COMMUNITY NURSING**

**411-048-0150**

**Purpose**

- (1) The rules in OAR chapter 411, division 048 establish standards and procedures for Medicaid enrolled providers who provide long term care community nursing services. Long term care community nursing services provide

ongoing registered nurse (RN) services to eligible individuals who are receiving Medicaid home and community-based services in a home-based or foster home setting.

(2) Long term care community nursing services provide:

(a) Evaluation and identification of supports that help an individual maintain maximum functioning and minimize health risks, while promoting the individual's autonomy and self management of healthcare;

(b) Teaching an individual's caregiver or family that is necessary to assure the individual's health and safety in a home-based or foster home setting;

(c) Delegation of nursing tasks to an individual's caregiver; and

(d) Case managers and health professionals with the information needed to maintain the individual's health, safety, and community living situation while honoring the individual's autonomy and choices.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070

#### **411-048-0160**

##### **Definitions**

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 048:

(1) "AAA" means the Area Agency on Aging designated by the Department that is responsible for providing a comprehensive and coordinated system of services to older adults and adults with disabilities in a designated planning and service area.

(2) "Abuse" means:

(a) Abuse of a child:

(A) As defined in ORS 419B.005; and

(B) As defined in OAR 407-045-0260, when a child resides in a foster home licensed by the Department to provide residential services to a child with intellectual or developmental disabilities.

(b) Abuse of an adult or older adult:

(A) As defined in ORS 124.050-095 and ORS 430.735-765; and

(B) As defined in OAR 407-045-0260 for individuals 18 years or older with intellectual or developmental disabilities that reside in a Department licensed adult foster home; or

(C) As defined in OAR 411-020-0002 for older adults and adults with a physical disability who are 18 years of age or older that reside in a Department licensed adult foster home.

(3) "Acute Care Nursing" means nursing services provided on an intermittent or time limited basis such as those provided by a hospice agency as defined in ORS 443.850, or a home health agency as defined in ORS 443.005. Acute care nursing may include direct service and is designed to address a specific task of nursing or a short term health condition.

(4) "Business Day" means the day that the "Local Office" is open for business.

(5) "Care Coordination" means the email, faxes, phone calls, meetings and other types of information exchange, consultation, and advocacy provided by a registered nurse on behalf of an individual that is necessary for the registered nurse to conduct assessments, complete medication reviews, provide for individual safety needs, and implement an individual's Nursing Service Plan.

(6) "Caregiver" means any person responsible for providing services to an eligible individual in a home-based or foster home setting. A caregiver may include an unlicensed person defined as a designated caregiver in OAR chapter 851, division 48 (Standards for Provision of Nursing Care by a Designated Caregiver).

(7) "Case Manager" means a person employed by the Department, Community Developmental Disability Program, or Area Agency on Aging who assesses the service needs of an applicant, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements an individual's plan for services and monitors the services delivered.

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

(9) "Community Nursing Services" means "long term care community nursing services" as defined in this rule.

(10) "Delegation" means the standards and processes described in OAR chapter 851, division 047 (Standards for Community Based Care Registered Nurse Delegation).

(11) "Department" means the Department of Human Services or the Department's designee.

(12) "Department Approved Form" means forms used by registered nurses and case managers to support these rules. The Department maintains these documents on the Department's website

(<http://www.oregon.gov/dhs/spd/pages/provtools/nursing/forms.aspx>). Printed copies may be obtained by contacting the Department of Human Services, ATTN: Rule Coordinator, 500 Summer Street NE, E10, Salem, OR 97301.

(13) "Direct Hands-on Nursing" means a registered nurse provides treatment or therapies directly to an individual instead of teaching or delegating the tasks of nursing to the individual's caregiver. Payment for direct hands-on nursing services is not reimbursed unless an exception has been granted by the Department as described in OAR 411-048-0170.

(14) "Documentation" means a written record of all services provided to, and for, an individual and an individual's caregiver that is maintained by the registered nurse as described in OAR 411-048-0200.

(15) "Enrolled Medicaid Provider" means an entity or individual that meets and completes all the requirements in these rules, OAR 407-120-0300 to 0400 (Medicaid Provider Enrollment and Claiming), and OAR chapter 410, division 120 (Medicaid General Rules) as applicable.

(16) "Foster Home" means any Department licensed or certified family home in which residential services are provided as described in:

(a) OAR chapter 411, division 050 for adult foster homes for older adults and adults with physical disabilities;

(b) OAR chapter 411, division 346 for foster homes for children with intellectual or developmental disabilities; and

(c) OAR chapter 411, division 360 for adult foster homes for individuals with intellectual or developmental disabilities.

(17) "Healthcare Provider" means a licensed provider providing services such as but not limited to home health, hospice, mental health, primary care, specialty care, durable medical equipment, pharmacy, or hospitalization to an eligible individual.

(18) "Home" means a non-licensed setting where an individual is receiving Medicaid home and community-based services.

(19) "Home and Community-Based Services" mean the services approved and funded by the Centers for Medicare and Medicaid Services for eligible individuals who are aged and physically disabled and for eligible individuals with intellectual disabilities and developmental disabilities in accordance with Title XIX of the Social Security Act.

(20) "Home Health Agency" has the meaning given that term in ORS 443.005.

(21) "Individual" means a person eligible for community nursing services under these rules.

(22) "In-Home Care Agency" has the meaning given that term in ORS 443.305.

(23) "Local Office" means the Department office, Area Agency on Aging, or Community Developmental Disability Program responsible for Medicaid services including case management, referral, authorization, and oversight of long term care community nursing services in the region where the individual lives and where the community nursing services are delivered.

(24) "Long Term Care Community Nursing Services" mean the nursing services provided under these rules to individuals living in a home-based or foster home setting where the monthly Medicaid home and community-based services rate does not include nursing services. Long term care community nursing services are a distinct set of services that focus on an individual's chronic and ongoing health and activity of daily living needs. Long term care community nursing services include an assessment, monitoring, delegation, teaching, and coordination of services that addresses an individual's health and safety needs in a Nursing Service Plan that supports individual choice and autonomy. The requirements in these rules are provided in addition to any nursing related requirements stipulated in the licensing rules governing the individual's place of residence.

(25) "Medication Review" means a review focused on an individual's medication regime that includes examination of the prescriber's orders and related administration records, consultation with a pharmacist or the prescriber, clarification of PRN (as needed) parameters, and the development of a teaching plan based upon the needs of the individual or the individual's caregiver. In an unlicensed setting, the medication review may include observation and teaching related to administration methods and storage systems.

(26) "Nursing Assessment" means one of the following assessments selected by the registered nurse based on an individual's need and situation:

(a) A "nursing assessment" as defined in OAR 851-047-0010 (Standards for Community Based Care Registered Nurse Delegation); or

(b) A "comprehensive assessment" or "focused assessment" as defined in OAR 851-045-0030 (Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse).

(27) "Nursing Service Plan" means the plan that is developed by a registered nurse based on an individual's initial nursing assessment, reassessment, or updates made to a nursing assessment as a result of monitoring visits.

(a) The Nursing Service Plan is specific to the individual and identifies the individual's diagnoses and health needs, the caregiver's teaching needs, and any care coordination, teaching, or delegation activities.

(b) The Nursing Service Plan is separate from the case manager's service plan, the foster home provider's service plan, and any service plans developed by other health professionals.

(c) Nursing service plans must meet the standards in OAR chapter 851, division 045 (Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse).

(28) "OSBN" means the Oregon State Board of Nursing. OSBN is the agency responsible for regulating nursing practice and education for the purpose of protecting the public's health, safety, and well-being.

(29) "Rate Schedule" means the communication tool issued by the Department to transmit rate changes to partners, subcontractors, and stakeholders. The Department maintains this document on the Department's website (<http://www.oregon.gov/dhs/spd/provtools/rateschedule.pdf>). Printed copies may be obtained by contacting the Department of Human Services, ATTN: Rule Coordinator, 500 Summer Street NE, E10, Salem, OR 97301.

(30) "RN" means a registered nurse licensed by the Oregon State Board of Nursing. An RN providing long term care community nursing services under these rules is either an independent contractor who is an enrolled Medicaid provider or an employee of an organization that is an enrolled Medicaid provider.

(31) "These Rules" mean the rules in OAR chapter 411, division 048.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070

#### **411-048-0170**

##### **Eligibility and Limitations**

(1) ELIGIBILITY. Community nursing services may be provided by an RN to an individual if the individual meets the following requirements:

(a) The individual must be determined eligible for Medicaid home and community-based services provided through the Department;

(b) The individual must be receiving services through one of the following:

(A) In-home supports for children with intellectual or developmental disabilities as described in OAR chapter 411, division 308;

(B) Adult foster homes for individuals with intellectual or developmental disabilities as described in OAR chapter 411, division 360;

(C) Foster homes for children with intellectual or developmental disabilities as described in OAR chapter 411, division 346;

(D) Comprehensive in home support for adults with intellectual or developmental disabilities as described in OAR chapter 411, division 330;

(E) Adult foster homes for older adults and adults with physical disabilities as described in OAR chapter 411, division 050;

(F) Independent Choices Program participants as described in OAR chapter 411, division 030;

(G) State Plan personal care participants as described in OAR chapter 411, division 034;

(H) 1915C Nursing Facility Waiver; or

(I) State Plan K Community First Choice;

(c) The individual must live in a home or a foster home as defined in OAR 411-048-0160;

(d) The individual must be referred by their case manager for long term care community nursing services.

Individuals may request long term community nursing services through their case manager.

(2) LIMITATIONS.

(a) Long term care community nursing services may not be provided to:

(A) A resident of a nursing facility, assisted living facility, residential care facility, 24-hour developmental disability group home, or intermediate care facility for individuals with intellectual or developmental disabilities;

(B) An individual enrolled in a brokerage or other support services not funded by Medicaid home and community-based services; or

(C) An individual enrolled in a program or residing in a setting where nursing services are provided under a monthly service rate.

(b) Case managers may not prior authorize long term care community nursing services that duplicate nursing services provided by Medicare or other Medicaid programs.

(c) Long term care community nursing services do not include nursing activities used for administrative functions such as protective service investigations, pre-admission screenings, eligibility determinations, licensing inspections, case manager assessments, or corrective action activities. This limitation does not include authorized care coordination as defined in OAR 411-048-0160.

(d) Long term care community nursing services do not include reimbursement for direct hands-on nursing as defined in OAR 411-048-0160.

(3) EXCEPTIONS. An exception to sections (2)(c) and (2)(d) of this rule may be requested as described in OAR 411-048-0250.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070

**DIVISION 65**  
**SPECIALIZED LIVING SERVICES CONTRACTS**

**411-065-0000**

**Purpose**

The purpose of these rules is to establish standards for specialized living service contracts. The standards provide an enhanced continuum of quality care in a home-like environment for specific target groups who are eligible for a live-in attendant, but because of special needs, are unable to live independently or receive services in other community-based care facilities and who would otherwise require nursing facility care. Services provided to residents in the Specialized Living Services Program are Medicaid home and community-based services, which may include specific services required because of physical, intellectual, or behavioral limitations in meeting self-care needs.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070

**DIVISION 70**  
**NURSING FACILITIES/MEDICAID – GENERALLY AND REIMBURSEMENT**  
**Nursing Facilities/Medicaid – Generally**

**411-070-0033**

**Post Hospital Extended Care Benefit**

(1) The post hospital extended care benefit (OAR 410-120-1210(4)) is an Oregon Health Plan benefit that consists of a stay of up to 20 days in a nursing facility to allow discharge from hospitals.

(2) The post hospital extended care benefit must be prior authorized by pre-admission screening for individuals not enrolled in managed care.

(3) To be eligible for the post hospital extended care benefit, the individual must meet all of the following:

(a) Be receiving Oregon Health Plan Plus or Standard, Fee-for-Service benefits;

(b) Not be Medicare eligible;

(c) Have a medically-necessary, qualifying hospital stay consisting of:

(A) A DMAP-paid admission to an acute-care hospital bed, not including a hold bed, observation bed, or emergency room bed.

(B) The stay must consist of three or more consecutive days, not counting the day of discharge.

(d) Transfer to a nursing facility within 30 days of discharge from the hospital;

(e) Need skilled nursing or rehabilitation services on a daily basis for a hospitalized condition meeting Medicare skilled criteria that may be provided only in a nursing facility meaning:

(A) The individual is at risk of further injury from falls, dehydration, or nutrition because of insufficient supervision or assistance at home;

(B) The individual's condition requires daily transportation to a hospital or rehabilitation facility by ambulance; or

(C) It is too far to travel to provide daily nursing or rehabilitation services in the individual's home.

(4) The individual may qualify for another 20 day post-hospital extended care benefit only if the individual has been out of a hospital and has not received skilled nursing care for 60 consecutive days in a row and meets all the criteria in this rule.

(5) Individuals eligible for the 20 day post-hospital extended care benefit are not eligible for long term care nursing facility or Medicaid home and community-based services unless the individual meets the eligibility criteria in OAR 411-015-0100 or OAR 411-320-0080.

Stat. Auth.: ORS 410.070 & 414.065

Stats. Implemented: ORS 410.070 & 414.065