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**PERMANENT ADMINISTRATIVE RULES**

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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
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Rules Coordinator	Telephone
500 Summer St. NE, E48, Salem, OR 97301	
Address	

To become effective 10/01/2014 Rulemaking Notice was published in the September 2014 Oregon Bulletin.

**RULE CAPTION**

Modified Adjusted Gross Income (MAGI) Eligibility

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:**

411-015-0005, 411-015-0006, 411-015-0008, 411-015-0015, 411-015-0100, 411-028-0010, 411-028-0020, 411-030-0020, 411-030-0040, 411-034-0010, 411-034-0030

**REPEAL:**

411-015-0005(T), 411-015-0006(T), 411-015-0015(T), 411-015-0100(T), 411-028-0010(T), 411-028-0020(T), 411-028-0030(T), 411-030-0020(T), 411-030-0040(T), 411-034-0010(T), 411-034-0030(T)

**RENUMBER:**

**AMEND AND RENUMBER:**

**Statutory Authority:**

ORS 410.070

**Other Authority:**

**Statutes Implemented:**

ORS 410.070

**RULE SUMMARY**

The Department of Human Services (Department) is permanently updating the rules in OAR 411-015, 030 and 034 to make permanent temporary rule language that became effective on April 21, 2014. The Department is taking out the Modified Adjusted Gross Income (MAGI) temporary language from 411-028 and putting the OSIPM language back in to the rule. Also, in 411-028, language about adult protective service investigators was removed as it is no longer applicable.

The Department is permanently updating the rules in OAR 411-015, 030 and 034 to expand eligibility for Medicaid funded long term care services, State Plan Personal Care, and State K-Plan to include the expanded Medicaid for Modified Adjusted Gross Income (MAGI) eligible individuals. This will be accomplished by changing the eligibility criteria in parts of the rule from OSIPM to Medicaid OHP Plus benefit package. Formatting, punctuation, and grammar issues in the rules were addressed as well.

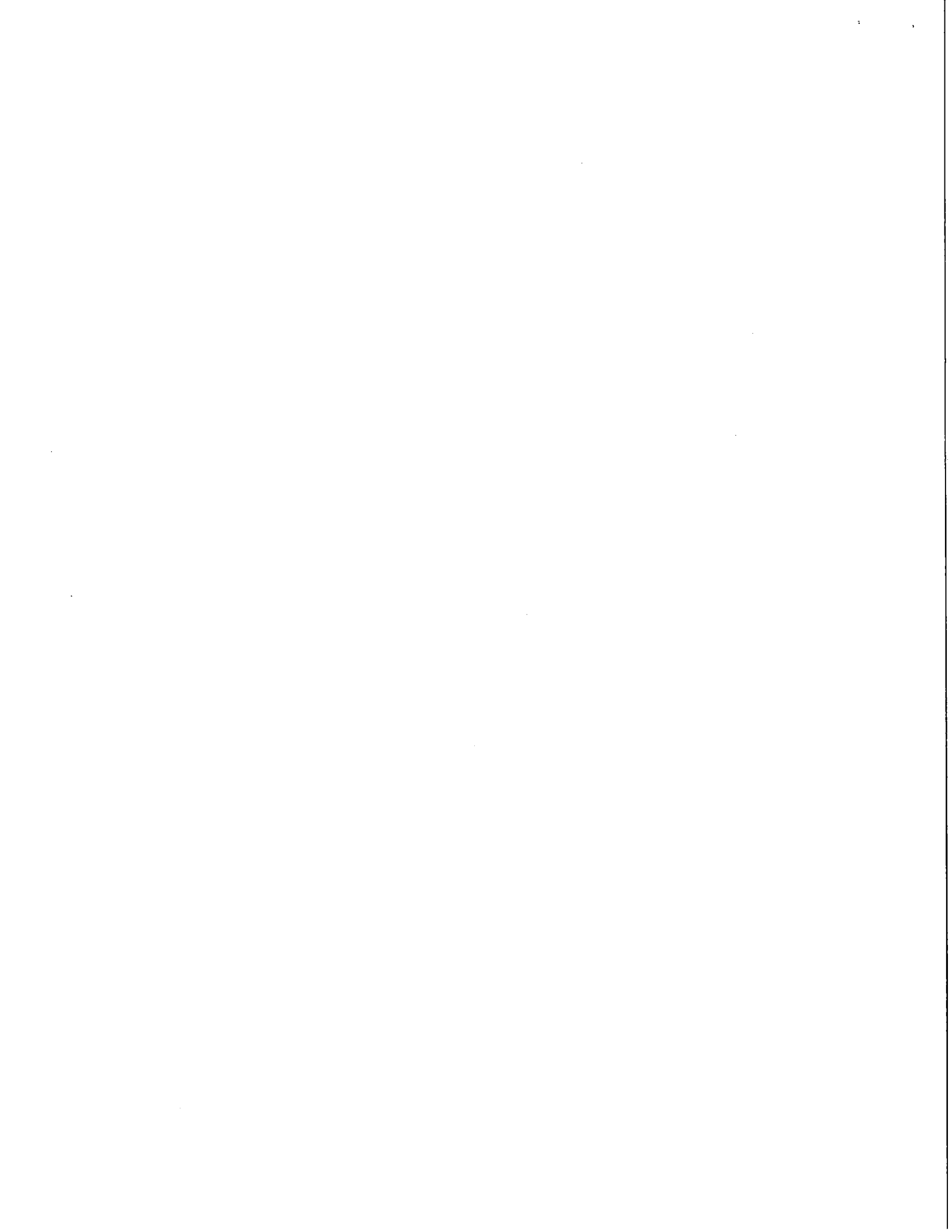
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APD 35-2014



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**PERMANENT ADMINISTRATIVE RULES**

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

411

Agency and Division

Administrative Rules Chapter Number

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Michael McCormick

9/29/14

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 15  
LONG-TERM CARE SERVICE PRIORITIES FOR  
INDIVIDUALS SERVED**

**411-015-0005**

**Definitions**

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 015:

- (1) "AAA" means "Area Agency on Aging" as defined in this rule.
- (2) "Adult" means any person at least 18 years of age.
- (3) "All Phases" means each part of an activity.
- (4) "Alternative Service Resources" means other possible resources for the provision of services to meet an individual's needs. Alternative service resources includes, but is not limited to, natural supports, risk intervention services, Older Americans Act programs, or other community supports. Alternative service resources are not paid by Medicaid.
- (5) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet the specific service needs of an eligible individual.
- (6) "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 term Area Agency on Aging (AAA) is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 to 410.300.
- (7) "Assistance Types" needed for activities of daily living and instrumental activities of daily living include but are not limited to the following terms:
  - (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.
- (8) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, instrument of technology, service animals, general household items, or furniture used to assist and enhance an individual's independence in performing any activity of daily living.
- (9) "Behavioral Care Plan" means a documented set of procedures, reviewed by the Department or AAA representative, which describes interventions for use by a provider to prevent, mitigate, or respond to behavioral symptoms that negatively impact the health and safety of an individual or others in a home or community-based services setting. The preferences of an individual are included in developing a Behavioral Care Plan.
- (10) "Business Days and Hours" means Monday through Friday and excludes Saturdays, Sundays, and state or federal holidays. Hours are from 8:00 AM to 5:00 PM.
- (11) "CA/PS" means "Client Assessment and Planning System" as defined in this rule.
- (12) "Care Setting" means a Medicaid contracted facility at which a Medicaid eligible individual resides and receives services. Care settings include adult foster homes, residential care facilities, assisted living facilities, specialized living contracted residences, and nursing facilities.
- (13) "Case Manager" means an employee of the Department or Area Agency on Aging who assesses the service needs of individuals, determines eligibility, and offers service choices to eligible individuals. The case manager authorizes and implements an individual's service plan and monitors the services delivered as described in OAR chapter 411, division 028.
- (14) "Client" means "individual" as defined in this rule.
- (15) "Client Assessment and Planning System (CA/PS)":
  - (a) Is the single entry data system used for --
    - (A) Completing a comprehensive and holistic assessment;
    - (B) Surveying an individual's physical, mental, and social functioning; and

- (C) Identifying risk factors, individual choices and preferences, and the status of service needs.
- (b) The CA/PS documents the level of need and calculates the individual's service priority level in accordance with these rules, calculates the service payment rates, and accommodates individual participation in service planning.
- (16) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices consist of all available services under the Medicaid home and community-based service options, the utilization of assistive devices, natural supports, architectural modifications, and alternative service resources not paid for by the Department.
- (17) "Department" means the Department of Human Services (DHS).
- (18) "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 defined in OAR 411-015-0006.
- (19) "Extraordinary Circumstances" means:
- (a) An individual being assessed is working full time during business hours; or
  - (b) A family member, whose presence is requested by an individual being assessed, is traveling from outside the area, and is available for only a limited period of time that does not include business days and hours.
- (20) "Functional Impairment" means an individual's pattern of mental and physical limitations that restricts the individual's ability to perform activities of daily living and instrumental activities of daily living without the assistance of another person.
- (21) "Independent" means an individual does not meet the definition of "assist" or "full assist" when assessing an activity of daily living as described in OAR 411-015-0006 or when assessing an instrumental activity of daily living as described in 411-015-0007.
- (22) "Individual" means an older adult or an adult with a disability applying for or eligible for services. The term "individual" is synonymous with "client".
- (23) "Medicaid Home and Community-Based Services" means the services approved and funded by the Centers for Medicare and Medicaid Services for eligible individuals in accordance with Title XIX of the Social Security Act.
- (24) "Medicaid OHP Plus Benefit Package" means only the Medicaid benefit packages provided under OAR 410-120-1210(4)(a) and (b). This excludes individuals receiving Title XXI benefits.
- (25) "Mental or Emotional Disorder" means:
- (a) A schizophrenic, mood, paranoid, panic, or other anxiety disorder;
  - (b) Somatoform, personality, dissociative, factitious, eating, sleeping, impulse control, or adjustment disorder; or
  - (c) Other psychotic disorder as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual.
- (26) "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.
- (27) "Older Adult" means any person at least 65 years of age.
- (28) "OSIPM" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIPM is Oregon Medicaid insurance coverage for individuals who meet eligibility criteria as described in OAR chapter 461.
- (29) "Service Priority Level (SPL)" means the order in which Department and Area Agency on Aging staff identify individuals eligible for a nursing facility level of care, Oregon Project Independence, or Medicaid home and community-based services. A lower service priority level number indicates greater or more severe functional impairment. The number is synonymous with the service priority level.
- (30) "SPL" means "service priority level" as defined in this rule.
- (31) "Substance Abuse Related Disorders" means disorders related to the taking of a drug or toxin of abuse (including alcohol).
- (a) Substance abuse related disorders include:
- (A) Substance dependency and substance abuse;
  - (B) Alcohol dependency and alcohol abuse; and
  - (C) Substance induced disorders and alcohol induced disorders as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual.
- (b) Substance abuse related disorders are not considered physical disabilities. Dementia or other long term physical or health impairments resulting from substance abuse may be considered physical disabilities.
- (32) "These Rules" means the rules in OAR chapter 411, division 015.

(33) "Without Supports" means an individual lacks the assistance of another person, a care setting and staff, or an alternative service resource as defined in this rule.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.060, 410.070, & 414.065

#### **411-015-0006**

##### **Activities of Daily Living (ADL)**

(1) "Activities of Daily Living (ADL)" mean those personal functional activities required by an individual for continued well-being which are essential for health and safety. Activities include eating, dressing, grooming, bathing, personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel and bladder management), and cognition, and behavior.

(2) Evaluation of the individual's need for assistance in Activities of Daily Living is based on:

(a) The individual's abilities rather than the services provided;

(b) How the individual functioned during the 30 days prior to the assessment date, with consideration of how the person is likely to function in the 30 days following the assessment date; and

(c) Evidence of the actual or predicted need for assistance of another person within the assessment time frame and it must not be based on possible or preventative needs.

(3) "Independent" means the individual does not meet the definition of "Assist" or "Full Assist" for each Activity of Daily Living as defined in this rule.

(4) Bathing and personal hygiene. Bathing and personal hygiene are comprised of two components. To be considered Assist, the individual must require assistance in bathing or full assistance in hygiene. To be considered Full Assist, the individual must require full assistance in bathing.

(a) Bathing means the activities of bathing and washing hair and using assistive devices if needed. Bathing includes the act of getting in and out of the bathtub or shower.

(A) Assist: Even with assistive devices, the individual is unable to accomplish some tasks of bathing without the assistance of another person. This means hands-on assistance for part of the task, cueing during the activity, or stand-by presence during the activity.

(B) Full Assist: Even with assistive devices, the individual is unable to accomplish any task of bathing without the assistance of another person. This means the individual needs hands-on assistance of another person through all phases of the activity, every time the activity is attempted.

(b) Personal hygiene means the activities of shaving, caring for the mouth, or assistance with the tasks of menstruation care.

(A) Assist: Even with assistive devices, the individual is unable to accomplish at least one task of personal hygiene without the assistance of another person. This means hands-on assistance for part of the task, cueing during the activity, or stand-by presence during the activity.

(B) Full Assist: Even with assistive devices, the individual is unable to accomplish at least two personal hygiene tasks, without the assistance of another person. This means the individual needs hands-on assistance of another person through all phases of the activity, every time the activity is attempted.

(5) Cognition and behavior refers to how the brain functions in the areas of adaptation, awareness, judgment, memory, and orientation. Cognition includes three components of behavioral symptoms which are demands on others, danger to self or others, and wandering.

(a) The individual's ability to manage each component of cognition and behavior is assessed by how the person functions without supports, meaning the assistance of another person, a care setting, or an alternative service resource as defined in OAR 411-015-0005. Lack of medication or lack of medication management is not considered when evaluating cognition or behavior.

(b) The assessment time frame in OAR 411-015-0008 of 30 days prior to the date of the assessment may be expanded when assessing cognition and behavior without supports. History or incidents in the past, more than 30 days prior to the assessment date, may be considered if they negatively impacted health and safety and are currently a concern that needs to be addressed.

(c) An individual under age 65, with cognition or behavior assistance or full assistance needs based on a mental or emotional disorder, does not meet the criteria for service eligibility per OAR 411-015-0015.

(d) An individual must require assistance in at least three of the eight components of cognition and behaviors to meet the criteria for assist in cognition and behaviors. An individual must require full assistance in three of the eight components to meet the criteria for full assistance in cognition and behaviors.

(A) Adaptation is the ability to respond, cope, and adjust to major life changes such as a change in living situation or a loss (such as health, close relationship, pet, divorce, or a death).

- (i) Assist: The individual requires reassurance from another person to cope with or adjust to change. Assistance involves multiple occurrences, less than daily.
- (ii) Full Assist: The individual requires constant emotional support and reassurance or is unable to adapt to change. These are daily, ongoing occurrences.
- (B) Awareness means the ability to understand basic health and safety needs (such as the need for food, shelter, and clothing).
- (i) Assist: The individual requires assistance of another person to understand basic health and safety needs.
- (ii) Full Assist: The individual does not have the ability to understand basic health and safety needs and requires daily, ongoing intervention by another person.
- (C) Judgment means decision-making. It is the ability to identify choices and understand the benefits, risks, and consequences of those choices. Individuals who lack the ability to understand choices, or the potential risks and consequences of choices, need assistance in decision-making. Judgment does not include what others might deem a poor choice.
- (i) Assist: At least weekly, the individual needs protection, monitoring, and guidance from another person to make decisions.
- (ii) Full Assist: The individual's decisions require daily intervention by another person.
- (D) Memory means the ability to remember and appropriately use current information impacting the health and safety of the individual.
- (i) Assist: The individual has difficulty remembering and using current information and requires reminding from another person.
- (ii) Full Assist: The individual is unable to remember or use information and requires assistance beyond reminding.
- (E) Orientation means the ability to accurately understand or recognize person, place, or time in order to maintain health and safety.
- (i) Assist: The individual is disoriented to person, place, or time and requires the assistance of another person. These occurrences are episodic during the week, but less than daily.
- (ii) Full Assist: The individual is disoriented daily to person, place, or time and requires the assistance of another person.
- (F) Danger to self or others means behavioral symptoms, other than wandering, that are hazardous to the individual (including self-injury), or harmful or disruptive to those around the individual.
- (i) Assist: At least monthly, the individual is disruptive or aggressive in a non-physical way, agitated, or sexually inappropriate and needs the assistance of another person. These behavioral symptoms are challenging, but the individual can be verbally redirected.
- (ii) Full Assist: The individual has had more than one episode of aggressive, disruptive, agitated, dangerous, or physically abusive or sexually aggressive behavioral symptoms directed at self or others. These behavioral symptoms are extreme, may be unpredictable, and necessitate intervention beyond verbal redirection, requiring an individualized behavioral care plan (as defined in OAR 411-015-0005) that all staff are trained to deliver.
- (G) Demands on others means behavioral symptoms, other than wandering, that negatively impact and affect living arrangements, providers, or other residents.
- (i) Assist: The individual's habits and emotional states limit the types of living arrangements and companions, but can be modified with individualized routines, changes to the environment (such as roommates or noise reduction), or general training for the provider that is not specific to the individual.
- (ii) Full Assist: The individual's habits and emotional states can be modified only with a 24-hour specialized care setting or an individualized behavioral care plan (as defined in OAR 411-015-0005) that all staff are trained to deliver.
- (H) Wandering means moving about aimlessly, or elopement, without relationship to needs or safety.
- (i) Assist: The individual wanders within the home or facility, but does not jeopardize safety.
- (ii) Full Assist: The individual wanders inside or outside and jeopardizes safety.
- (6) Dressing and Grooming is comprised of two elements. To be considered Assist, the individual must require assistance in dressing or full assistance in grooming. To be considered Full Assist the individual must require full assistance in dressing:
- (a) Dressing means the activities of dressing and undressing.
- (A) Assist: Even with assistive devices, the individual is unable to accomplish some tasks of dressing without the assistance of another person. This means hands-on assistance for part of the task, cueing during the activity, or stand-by presence during the activity.

(B) Full Assist: Even with assistive devices, the individual is unable to accomplish any tasks of dressing without the assistance of another person. This means the individual needs hands-on assistance through all phases of the activity, every time the activity is attempted.

(b) Grooming means nail and hair care.

(A) Assist: Even with assistive devices, the individual is unable to accomplish tasks of grooming, without the assistance of another person. This means hands-on assistance for part of the task, cueing during the activity, or stand-by presence during the activity.

(B) Full Assist: Even with assistive devices, the individual is unable to perform any tasks of grooming without the assistance of another person. This means the individual needs hands-on assistance of another person through all phases of the activity, every time the activity is attempted.

(7) Eating means the activity of feeding and eating and may include using assistive devices.

(a) Assist: When eating, the individual requires another person to be within sight and immediately available. Assistance requires hands-on feeding, hands-on assistance with special utensils, cueing during the act of eating, or monitoring to prevent choking or aspiration. Assistance with eating is a daily need or may vary if an individual's medical condition fluctuates significantly during a one-month period.

(b) Full Assist: When eating, the individual always requires one-on-one assistance for direct feeding, constant cueing, or to prevent choking or aspiration. This includes nutritional IV or feeding tube set-up by another person. This means the individual needs the assistance of another person through all phases of the activity, every time the activity is attempted.

(8) Elimination is comprised of three components. To be considered Assist, the individual must require assistance in at least one of the three components. To be considered Full Assist the individual must require full assistance in any of the three components. Dialysis care needs are not assessed as part of elimination.

(a) Bladder means managing bladder care. This includes tasks such as catheter care, toileting schedule, monitoring for infection, ostomy care, and changing incontinence supplies.

(A) Assist: Even with assistive devices or supplies, the individual is unable to accomplish some of the tasks of bladder care without at least monthly assistance from another person.

(B) Full Assist: The individual is unable to manage any part of bladder or catheter care without the assistance of another person. This means the individual needs the assistance of another person through all phases of the activity, every time the activity is attempted.

(b) Bowel means managing bowel care. This includes tasks such as digital stimulation, toileting schedule, suppository insertion, ostomy care, enemas, and changing incontinence supplies.

(A) Assist: Even with assistive devices the individual is unable to accomplish some tasks of bowel care without at least monthly assistance of another person.

(B) Full Assist: The individual is unable to accomplish any part of bowel care without the assistance of another person. This means the individual needs the assistance of another person through all phases of the activity, every time the activity is attempted.

(c) Toileting means the activity of getting to and from, and on and off the toilet (including bedpan, commode, or urinal), cleansing after elimination or adjusting clothing, cleaning and maintaining assistive devices, or cleaning the toileting area after elimination because of unsanitary conditions that pose a health risk. This does not include routine bathroom cleaning.

(A) Assist: Even with assistive devices, the individual is unable to accomplish some tasks of toileting without hands-on assistance of another person at least monthly. Hands-on assistance is required for all tasks, except tasks associated with cleaning devices or the toileting area.

(B) Full Assist: The individual is unable to accomplish any part of toileting without the assistance of another person. This means the individual needs hands-on assistance of another person through all phases of the activity, every time the activity is attempted. Hands-on assistance is required for all tasks, except tasks associated with cleaning devices or the toileting area.

(9) Mobility is comprised of two components, which are ambulation and transfer. In the mobility cluster only, assistance is categorized into three levels. To be considered Minimal Assist, the individual must require minimal assistance in ambulation. To be considered Substantial Assist, the individual must require substantial assistance with ambulation or an assist with transfer. To be considered Full Assist, the individual must require full assistance with ambulation or transfer.

(a) Mobility does not include getting in and out of a motor vehicle, getting in or out of a bathtub or shower, moving on or off the toilet, or moving to and from the toilet.

(b) Mobility, for the purposes of this rule, inside the home or care setting, means inside the entrance to the client's home or apartment unit or inside the care setting (as defined in OAR 411-015-0005). Courtyards, balconies, stairs or hallways exterior to the doorway of the home or apartment unit are not considered inside.

(c) A history of falls with an inability to rise without the assistance of another person, or with negative physical health consequences, may be considered in assessing ambulation or transfer if they occur within the assessment time frame. Falls prior to the assessment time frame, or the need for prevention of falls alone, even if recommended by medical personnel, is not sufficient to qualify for assistance in ambulation or transfer.

(d) Ambulation means the activity of moving around both inside and outside the home or care setting, during the assessment time frame, while using assistive devices, if needed. Ambulation does not include exercise or physical therapy.

(A) Minimal Assist: Even with assistive devices, if needed, the individual can get around inside his or her home or care setting without the assistance of another person. Outside of the individual's home or care setting, the individual requires hands-on assistance of another person.

(B) Substantial Assist: Even with assistive devices, the individual is unable to ambulate during the assessment time frame without hands-on assistance of another person inside his or her home or care setting. Even with assistive devices, this assistance may also be needed outside.

(C) Full Assist: Even with assistive devices, the individual is unable to ambulate without assistance from another person. This means the individual needs the hands-on assistance of another person through all phases of the activity, every time the activity is attempted.

(e) Transfer means the activity of moving to or from a chair, bed, or wheelchair using assistive devices, if needed. This assistance must be needed inside the individual's home or care setting.

(A) Assist: Even with assistive devices, the individual is unable to accomplish a transfer without hands-on assistance of another person at least four days during a month.

(B) Full Assist: Even with assistive devices, the individual is unable to transfer and is dependent on at least one other person to perform the transfer. This means the individual needs hands-on assistance of another person through all phases of the activity, every time the activity is attempted.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070

#### **411-015-0008**

##### **Assessments**

###### **(1) ASSESSMENT.**

(a) The assessment process:

(A) Identifies an individual's ability to perform activities of daily living and instrumental activities of daily living (self-management tasks);

(B) Determines an individual's ability to address health and safety concerns; and

(C) Includes an individual's preferences to meet service needs.

(b) A case manager must conduct an assessment in accordance with the standards of practice established by the Department.

(c) A case manager must assess an individual's abilities, regardless of, architectural modifications, assistive devices, or services provided in a care setting, alternative service resources, or other community providers.

(d) The time frame of reference for evaluation is 30 days prior to the assessment date, with consideration of how the individual is likely to function in the 30 days following the assessment date.

(A) In order to be eligible, an individual must demonstrate the need for assistance of another person within the assessment time frame and expect the need to be on-going beyond the assessment time frame.

(B) The time frame for assessing the cognition and behavior activity of daily living may be extended as described in OAR 411-015-0006.

(e) The assessment must be conducted at least annually, or when requested by an individual, with a standardized assessment tool, approved by a Department case manager, or other qualified Department or AAA representative.

(f) The initial assessment must be conducted face to face, in an individual's home or care setting.

(g) All re-assessments must be conducted face to face in an individual's home or care setting, unless there is a compelling reason to meet elsewhere and the individual requests an alternative location. Case managers must visit an individual's home or care setting to complete the re-assessment and identify service plan needs, as well as safety and risk concerns.

(A) Individuals must be sent a notice of the need for re-assessment a minimum of 14 days in advance.

(B) Consumer requested re-assessments based on a change in the consumer's condition or service needs are exempt from the 14-day advance notice requirement.

(h) An individual may request the presence of natural supports at any assessment.

(i) Assessment times must be scheduled within business days and hours unless extraordinary circumstances necessitate an alternate time. If an alternate time is necessary, an individual must request the after-hours appointment, and coordinate a mutually acceptable appointment time with the local Department or AAA office.

(j) An individual, or the individual's representative, has the responsibility to participate, in and provide information necessary to, complete assessments and re-assessments within the time frame requested by the Department.

(A) Failure to participate in or provide requested assessment or re-assessment information within the application time frame, results in a denial of service eligibility.

(B) The Department may allow additional time if circumstances beyond the control of the individual or the individual's representative prevent timely participation or submission of information.

## (2) SERVICE PLAN.

(a) An individual being assessed, others identified by the individual, and a case manager must consider the service options as well as assistive devices, architectural modifications, and other alternative service resources as defined in OAR 411-015-0005 to meet an individual's service needs identified in the assessment process.

(b) A case manager is responsible for:

(A) Determining eligibility for specific services;

(B) Presenting service options, resources, and alternatives to an individual to assist the individual in making informed choices and decisions;

(C) Identifying goals, preferences, and risks; and

(D) Assessing the cost effectiveness of an individual's service plan.

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

(d) An eligible individual, or the individual's representative, is responsible for choosing and assisting in developing less costly service alternatives.

(e) The service plan payment must be considered full payment for the Medicaid home and community-based services rendered. Under no circumstances, may any provider demand or receive additional payment for Medicaid home and community-based services from an eligible individual or any other source.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.070

## **411-015-0015**

### **Current Limitations**

(1) The Department has the authority to establish, by administrative rule, service eligibility within which to manage the Department's limited resources. The Department is currently able to serve:

(a) Individuals determined eligible for the Medicaid OHP Plus benefit package who are assessed as meeting at least one of the service priority levels (1) through (13) as described in OAR 411-015-0010.

(b) Individuals eligible for Oregon Project Independence funded services, if the individual meets at least one of the service priority levels (1) through (18) of OAR 411-015-0010.

(c) Individuals needing risk intervention services in areas designated to provide such services. Individuals with the lowest service priority level number under OAR 411-015-0010 are served first.

(2) Individuals 65 years of age or older, determined eligible for developmental disability services, or having a primary diagnosis of a mental or emotional disorder, are eligible for nursing facility or Medicaid home and community-based services if:

(a) The individual meets section (1) of this rule; and

(b) The individual is not in need of specialized mental health treatment services or other specialized Department residential program interventions as identified through the mental health assessment process or PASRR process described in OAR 411-070-0043.

(3) Individuals under 65 years of age, determined eligible for developmental disability services, or having a primary diagnosis of a mental or emotional disorder, are not eligible for Department nursing facility services unless determined appropriate through the PASRR process described in OAR 411-070-0043.

(4) Individuals under 65 years of age determined to be eligible for developmental disability services are not eligible for Medicaid home and community-based services administered by the Department's Aging and People with Disabilities. Eligibility for Medicaid home and community-based services for individuals with intellectual or developmental disabilities is determined by the Department's Office of Developmental Disability Services or designee.

(5) Individuals under 65 years of age who have a diagnosis of mental or emotional disorder or substance abuse related disorder are not eligible for Medicaid home and community-based services administered by the Department's Aging and People with Disabilities unless:

(a) The individual has a medical non-psychiatric diagnosis or physical disability;

(b) The individual's need for services is based on his or her medical, non-psychiatric diagnosis, or physical disability; and

(c) The individual provides supporting documentation demonstrating that his or her need for services is based on the medical, non-psychiatric diagnosis, or physical disability. The Department authorizes documentation sources through approved and published policy transmittals.

(6) Medicaid home and community-based services are not intended to replace a natural support system as defined by OAR 411-015-0005. Paid support is provided if a natural support is unwilling or unable to provide identified services.

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

Stat. Auth.: ORS 410.070 & 411.070

Stats. Implemented: ORS 410.070

#### **411-015-0100**

##### **Eligibility for Nursing Facility or Medicaid Home and Community-Based Services**

(1) To be eligible for nursing facility services or Medicaid home and community-based services, a person must:

(a) Be age 18 or older.

(b) Be eligible for the Medicaid OHP Plus benefit package.

(A) An individual receiving Medicaid OHP Plus under OAR 410-200 coverage for services in a nonstandard living arrangement (see OAR 461-001-0000) is subject to the rules regarding transfer of assets (see OAR 461-140-0210 to 461-140-0300) in the same manner as if they were requesting these services under OSIPM. This includes, but is not limited to, the following assets:

(i) An annuity is evaluated according to OAR 461-145-0022;

(ii) A transfer of property when an individual retains a life estate is evaluated according to OAR 461-145-0310;

(iii) A loan made by an individual is evaluated according to OAR 461-145-0330;

(iv) An Irrevocable trust is evaluated according to OAR 461-145-0540;

(B) When an individual is disqualified for a transfer of assets they must receive a notice meeting the requirements of OAR 461-175-0310 in the same manner as if they were requesting services under OSIPM.

(c) Meet the functional impairment level within the service priority levels currently served by the Department as outlined in OAR 411-015-0010 and the requirements in OAR 411-015-0015.

(2) To be eligible for services paid through the Spousal Pay Program, an individual must meet the requirements listed above in section (1) of this rule in addition to the requirements in OAR 411-030-0080.

(3) Individuals who are age 17 or younger and reside in a nursing facility, are eligible for nursing facility services only and are not eligible to receive Medicaid home and community-based services administered by the Department's Aging and People with Disabilities.

Stat. Auth.: ORS 410.070

Stats. Implemented: ORS 410.060, 410.070, & 414.065

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

**CHAPTER 411  
DIVISION 28**

**CASE MANAGEMENT SERVICES FOR OLDER ADULTS AND ADULTS WITH DISABILITIES**

#### **411-028-0010**

##### **Definitions**

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 028:

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

- (2) "Adult Protective Services" mean the services provided in response to the need for protection from abuse described in OAR chapter 411, division 020, OAR chapter 407, division 045, and OAR chapter 943, division 045.
- (3) "Case Management" means the functions described in OAR 411-028-0020 performed by a case manager or higher level management staff.
- (4) "Case Manager" means a Department employee or an employee of the Department's designee that meets the minimum qualifications in OAR 411-028-0040 who is responsible for service eligibility, assessment of need, offering service choices to eligible individuals, service planning, service authorization and implementation, and evaluation of the effectiveness of Medicaid home and community-based services.
- (5) "Collateral Contact" means contact by a case manager with others who may provide information regarding an individual's health, safety, functional needs, social needs, or effectiveness of the individual's plan for services. Collateral contact may include family members, service providers, medical providers, neighbors, pharmacy staff, friends, or other professionals involved in the service coordination of an individual receiving Medicaid home and community-based services.
- (6) "Department" means the Department of Human Services.
- (7) "Designee" means an organization that the Department contracts with or has an interagency agreement with for the purposes of providing case management services.
- (8) "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 defined in OAR 411-015-0006.
- (9) "Individual" means an older adult or an adult with a disability applying for or determined eligible for Medicaid home and community-based services.
- (10) "Medicaid Home and Community-Based Services" mean the services for older adults and adults with disabilities approved for Oregon by the Centers for Medicare and Medicaid Services.
- (11) "Older Adult" means any person at least 65 years of age.
- (12) "OSIPM" means Oregon Supplemental Income Program-Medical as defined in OAR 461-101-0010. OSIPM is Oregon Medicaid insurance coverage for individuals who meet eligibility criteria as described in OAR chapter 461.
- (13) "Representative" is a person either appointed by an individual to participate in service planning on the individual's behalf or a person with longstanding involvement in assuring the individual's health, safety, and welfare. Stat. Auth.: ORS 410.070  
Stats. Implemented: ORS 410.070

#### **411-028-0020**

##### **Scope of Case Management Services**

- (1) **DIRECT CASE MANAGEMENT SERVICES.** Direct case management services are provided by a case manager or higher level staff, who communicates directly with an individual or the individual's representative. Direct case management services may occur by phone call, face-to-face contact, or email. Direct case management services do not include contact with collateral contacts unless the collateral contact is the individual's authorized representative. Direct case management services include:
- (a) An assessment as described in OAR 411-015-0008.
  - (b) Service Plan development and review as described in OAR 411-015-0008.
  - (c) Service options choice counseling as described in OAR 411-030-0050.
  - (d) Risk assessment and monitoring:
    - (A) Identifying and documenting risks;
    - (B) Working with an individual to eliminate or reduce risks;
    - (C) Developing and implementing a Risk Mitigation Plan;
    - (D) Monitoring risks over time; and
    - (E) Making adjustments to an individual's Service Plan as needed.
  - (e) Diversion activities. This means assisting an individual with finding alternatives to nursing facility admission.
  - (f) Other program coordination. This means helping an individual navigate or coordinate with other social, health, and assistance programs.
  - (g) Crisis response and intervention. This means assisting an individual with problem resolution.
  - (h) Service provision issues. This means assisting an individual with problem solving to resolve issues that occur with providers, services, or hours that don't meet the individual's needs.
- (2) **INDIRECT CASE MANAGEMENT SERVICES.** Indirect case management services are services provided by a case manager or higher level staff, in which direct contact with an individual is not occurring. Indirect case management services include:

- (a) Monitoring Service Plan implementation. Reviewing implementation of an individual's Service Plan by reviewing and comparing authorized and billed services to ensure that adequate services are being provided.
  - (b) Service options choice counseling. This means assisting an individual's caregiver, family member, or other support person with understanding all available Medicaid home and community-based service options.
  - (c) Risk monitoring. Working with a collateral contact to review an individual's risks, eliminate or reduce risks, and develop and implement a Risk Mitigation Plan. Adjustments to an individual's Service Plan based on risk monitoring activities are classified as direct case management.
  - (d) Diversion activities. This means finding alternatives to nursing facility admission. Diversion activities do not include transition activities to help an individual move from a nursing facility.
  - (e) Adult protective services referral including collateral contact.
  - (f) Other program coordination. This means helping collateral contacts navigate or coordinate with other social, health, and assistance programs.
  - (g) Service provision issues. This means assisting with problem solving issues that occur with providers, services, or hours that do not meet an individual's needs.
  - (h) Other case management activities not included in any criteria in this section of the rule.
- Stat. Auth.: ORS 410.070  
 Stats. Implemented: ORS 410.070

**DIVISION 30  
 IN-HOME SERVICES**

**411-030-0020**

**Definitions**

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

- (1) "AAA" means "Area Agency on Aging" as defined in this rule.
- (2) "Activities of Daily Living (ADL)" mean those personal, functional activities required by an individual for continued well-being, which are essential for health and safety. Activities include eating, dressing, grooming, bathing, personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition, and behavior as defined in OAR 411-015-0006.
- (3) "ADL" means "activities of daily living" as defined in this rule.
- (4) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet a specific service need of an eligible individual.
- (5) "Area Agency on Aging (AAA)" means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to individuals in a planning and service area. The term Area Agency on Aging is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 and described in ORS 410.210 to 410.300.
- (6) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living. Assistive devices include the use of service animals, general household items, or furniture to assist the individual.
- (7) "Business Days" means Monday through Friday and excludes Saturdays, Sundays, and state or federal holidays.
- (8) "CA/PS" means the "Client Assessment and Planning System" as defined in this rule.
- (9) "Case Manager" means an employee of the Department or Area Agency on Aging who assesses the service needs of an individual applying for services, determines eligibility, and offers service choices to the eligible individual. The case manager authorizes and implements an individual's service plan and monitors the services delivered as described in OAR chapter 411, division 028.
- (10) "Client Assessment and Planning System (CA/PS)":
  - (a) Is a single entry data system used for --
    - (A) Completing a comprehensive and holistic assessment;
    - (B) Surveying an individual's physical, mental, and social functioning; and
    - (C) Identifying risk factors, individual choices and preferences, and the status of service needs.
  - (b) The CA/PS documents the level of need and calculates an individual's service priority level in accordance with the rules in OAR chapter 411, division 015, calculates the service payment rates, and accommodates individual participation in service planning.
- (11) "Collective Bargaining Agreement" means the ratified Collective Bargaining Agreement between the Home Care Commission and the Service Employees International Union, Local 503. The Collective Bargaining Agreement is maintained on the Department's website: (<http://www.oregon.gov/dhs/spd/adv/hcc/docs/contract1113.pdf>). Printed

copies may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Aging and People with Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301-1067.

(12) "Consumer" or "Consumer-Employer" means an individual eligible for in-home services.

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

(14) "Contingency Fund" means a monetary amount that continues month to month if approved by a case manager that is set aside in the Independent Choices Program service budget to purchase identified items that substitute for personal assistance.

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

(16) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices consist of all available services under the Medicaid home and community-based service options, the utilization of assistive devices, natural supports, architectural modifications, and alternative service resources (defined in OAR 411-015-0005). Less costly alternatives may include resources not paid for by the Department.

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

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

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

(20) "DMAP" means the Oregon Health Authority, Division of Medical Assistance Programs.

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

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

(23) "Exception" means an approval for payment of a service plan granted to a specific individual in their current residence or in the proposed residence identified in the exception request that exceeds the CA/PS assessed service payment levels for individuals residing in community-based care facilities or the maximum hours of service as described in OAR 411-030-0070 for individuals residing in their own homes or the home of a relative. The approval of an exception is based on the service needs of the individual and is contingent upon the individual's service plan meeting the requirements in OAR 411-027-0020, OAR 411-027-0025, and OAR 411-027-0050. The term "exception" is synonymous with "exceptional rate" or "exceptional payment."

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

(25) "Financial Accountability" refers to guidance and oversight which act as fiscal safeguards to identify budget problems on a timely basis and allow corrective action to be taken to protect the health and welfare of individuals.

(26) "FUTA" is the acronym for Federal Unemployment Tax Assessment which is a United States payroll (or employment) tax imposed by the federal government on both employees and employers.

(27) "Homecare Worker" means a provider, as described in OAR 411-031-0040, that is directly employed by a consumer to provide either hourly or live-in services to the eligible consumer.

(a) The term homecare worker includes:

(A) A consumer-employed provider in the Spousal Pay and Oregon Project Independence Programs;

(B) A consumer-employed provider that provides state plan personal care services to individuals; and

(C) A relative providing Medicaid in-home services to an individual living in the relative's home.

(b) The term homecare worker does not include an Independent Choices Program provider or a personal support worker enrolled through Developmental Disability Services or the Addictions and Mental Health Division.

(28) "Hourly Services" mean the in-home services, including activities of daily living and instrumental activities of daily living, that are provided at regularly scheduled times.

(29) "IADL" means "instrumental activities of daily living" as defined in this rule.

(30) "ICP" means "Independent Choices Program" as defined in this rule.

(31) "Independent Choices Program (ICP)" means a self-directed in-home services program in which a participant is given a cash benefit to purchase goods and services identified in the participant's service plan and prior approved by the Department or Area Agency on Aging.

- (32) "Individual" means a person age 65 or older, or an adult with a physical disability, applying for or eligible for services.
- (33) "Individualized Back-Up Plan" means a plan incorporated into an Independent Choices Program service plan to address critical contingencies or incidents that pose a risk or harm to a participant's health and welfare.
- (34) "In-Home Services" mean the activities of daily living and instrumental activities of daily living that assist an individual to stay in his or her own home or the home of a relative.
- (35) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in IADL are identified in OAR 411-015-0007.
- (36) "Liability" refers to the dollar amount an individual with excess income contributes to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.
- (37) "Live-In Services" mean services provided when an individual requires activities of daily living, instrumental activities of daily living, and twenty-four hour availability. Time spent by any live-in employee doing instrumental activities of daily living and twenty-four hour availability are exempt from federal and state minimum wage and overtime requirements.
- (38) "Medicaid OHP Plus Benefit Package" means only the Medicaid benefit packages provided under OAR 410-120-1210(4)(a) and (b). This excludes individuals receiving Title XXI benefits.
- (39) "Natural Supports" or "Natural Support System" means resources and supports (e.g. relatives, friends, neighbors, significant others, roommates, or the community) who are willing to voluntarily provide services to an individual without the expectation of compensation. Natural supports are identified in collaboration with the individual and the potential "natural support". The natural support is required to have the skills, knowledge, and ability to provide the needed services and supports.
- (40) "Oregon Project Independence (OPI)" means the program of in-home services described in OAR chapter 411, division 032.
- (41) "Participant" means an individual eligible for the Independent Choices Program.
- (42) "Provider" means the person who renders the services.
- (43) "Rate Schedule" means the rate schedule maintained by the Department at <http://www.dhs.state.or.us/spd/tools/program/osip/rateschedule.pdf>. Printed copies may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Aging and People with Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301-1064.
- (44) "Relative" means a person, excluding an individual's spouse, who is related to the individual by blood, marriage, or adoption.
- (45) "Representative" is a person either appointed by an individual to participate in service planning on the individual's behalf or an individual's natural support with longstanding involvement in assuring the individual's health, safety, and welfare. There are additional responsibilities for an Independent Choices Program (ICP) representative as described in OAR 411-030-0100. An ICP representative is not a paid employee provider regardless of relationship to a participant.
- (46) "Service Budget" means a participant's plan for the distribution of authorized funds that are under the control and direction of the participant within the Independent Choices Program. A service budget is a required component of the participant's service plan.
- (47) "Service Need" means the assistance an individual requires from another person for those functions or activities identified in OAR 411-015-0006 and OAR 411-015-0007.
- (48) "SUTA" is the acronym for State Unemployment Tax Assessment. State unemployment taxes are paid by employers to finance the unemployment benefit system that exists in each state.
- (49) "These Rules" mean the rules in OAR chapter 411, division 030.
- (50) "Twenty-Four Hour Availability" means the availability and responsibility of a homecare worker to meet activities of daily living and instrumental activities of daily living needs of a consumer as required by the consumer over a twenty-four hour period. Twenty-four hour availability services are provided by a live-in homecare worker and are exempt from federal and state minimum wage and overtime requirements.
- Stat. Auth.: ORS 409.050, 410.070, & 410.090  
Stats. Implemented: ORS 410.010, 410.020, & 410.070

#### **411-030-0040**

##### **Eligibility Criteria**

- (1) In-home services are provided to individuals who meet the established priorities for service as described in OAR chapter 411, division 015 who have been assessed to be in need of in-home services.

- (a) Payments for in-home services are not intended to replace the resources available to an individual from the individual's natural supports.
- (b) An individual whose service needs are sufficiently and appropriately met by available natural supports is not eligible for in-home services.
- (2) An individual receiving Medicaid in-home services must:
  - (a) Meet the established priorities for service as described in OAR chapter 411, division 015;
  - (b) Be a current recipient of a Medicaid OHP Plus benefit package. Recipients receiving Medicaid OHP Plus benefits are subject to the transfer of assets rule criteria described in section (1)(b) of OAR 411-015-0100;
  - (c) Reside in a living arrangement described in OAR 411-030-0033; and
  - (d) Be 18 years of age or older.
- (3) An individual receiving services through the Independent Choices Program must:
  - (a) Meet the established priorities for service as described in OAR chapter 411, division 015;
  - (b) Be a current recipient of OSIPM (Oregon Supplemental Income Program Medical).
  - (c) Reside in a living arrangement described in OAR 411-030-0033; and
  - (d) Be 18 years of age or older.
- (4) To be eligible for Medicaid in-home services, an individual must employ an enrolled homecare worker or contracted in-home care agency. To be eligible for ICP, a participant must employ an employee provider.
- (5) Initial eligibility for Medicaid in-home services, or the ICP, does not begin until an individual's service plan has been authorized by the Department or the Department's designee. The service plan must identify the provider who delivers the authorized services, include the date when the provision of services begins, and include the maximum number of hours authorized. Service plans must be based upon the least costly means of providing adequate services.
- (6) If, for any reason, the employment relationship between an individual and provider is discontinued, an enrolled homecare worker or contracted in-home care agency must be employed within 14 business days for the individual to remain eligible for in-home services. A participant of ICP must employ an employee provider within 14 business days to remain eligible for ICP services. The individual's case manager has the authority to waive the 14 business day restriction if the individual is making progress towards employing a provider.
- (7) An eligible individual who has been receiving in-home services who temporarily enters a nursing facility or medical institution must employ an enrolled homecare worker or contracted in-home care agency within 14 business days of discharge from the facility or institution for the individual to remain eligible for in-home services. A participant of ICP must employ an employee provider within 14 business days of discharge to remain eligible for ICP services.
- (8) EMPLOYER RESPONSIBILITIES.
  - (a) In order to be eligible for in-home services provided by a homecare worker, an individual must be able to, or designate a representative to --
    - (A) Locate, screen, and hire a qualified homecare worker;
    - (B) Supervise and train the homecare worker;
    - (C) Schedule the homecare worker's work, leave, and coverage;
    - (D) Track the hours worked and verify the authorized hours completed by the homecare worker;
    - (E) Recognize, discuss, and attempt to correct any performance deficiencies with the homecare worker; and
    - (F) Discharge an unsatisfactory homecare worker.
  - (b) Individuals who are unable to meet the responsibilities in subsection (a) of this section are ineligible for in-home services provided by a homecare worker. Except as set forth in subsection (f) of this section, individuals ineligible for in-home services provided by a homecare worker may designate a representative to manage the individual's responsibilities as an employer on the individual's behalf. A representative of an individual may not be a homecare worker providing homecare worker services to the individual. Individuals must also be offered other available community-based service options to meet the individual's service needs, including contracted in-home care agency services, nursing facility services, or other community-based service options.
  - (c) An individual determined ineligible for in-home services provided by a homecare worker and who does not have a representative may request in-home services provided by a homecare worker at the individual's next re-assessment, but no sooner than 12 months from the date the individual was determined ineligible. To reestablish eligibility for in-home services provided by a homecare worker, an individual must attend training and acquire, or otherwise demonstrate, the ability to meet the employer responsibilities in subsection (a) of this section. Improvements in health and cognitive functioning, for example, may be factors in demonstrating the individual's ability to meet the employer responsibilities in subsection (a) of this section. If the Department determines an individual may not meet

the individual's employer responsibilities, the Department may require the individual appoint an acceptable representative.

(d) The Department retains the right to approve the representative selected by an individual. Approval may be based on, but is not limited to, the representative's criminal history, protective services history, or credible allegations of fraud or collusion in fraudulent activities involving a public assistance program.

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

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

(9) REPRESENTATIVE.

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

(b) An individual with a guardian must have a representative for service planning purposes. A guardian may designate themselves as the representative.

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

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

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

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

(11) Residents of licensed community-based care facilities, nursing facilities, prisons, hospitals, and other institutions that provide assistance with ADLs, are not eligible for in-home services.

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

Stat. Auth.: ORS 409.050, 410.070, & 410.090

Stats. Implemented: ORS 410.010, 410.020, & 410.070

#### **DIVISION 34**

#### **STATE PLAN PERSONAL CARE SERVICES**

#### **411-034-0010**

##### **Definitions**

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

(1) "AAA" means "Area Agency on Aging" as defined in this rule.

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

(3) "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.

(4) "Assistance" means an individual requires help from another person with the personal care or supportive services described in OAR 411-034-0020. Assistance may include cueing, hands-on, monitoring, reassurance, redirection, set-up, standby, or support as defined in OAR 411-015-0005. Assistance may also require verbal reminding to complete one of the tasks described in OAR 411-034-0020.

(5) "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.

(6) "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.

(7) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210.

(8) "Case Management" means the functions performed by a case manager, services coordinator, personal agent, or manager. Case management includes determining service eligibility, developing a plan of authorized services, and monitoring the effectiveness of services.

(9) "Case Manager" means a Department employee or an employee of the Department's designee, services coordinator, or personal agent 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.

(10) "Central Office" means the main office of the Department, Division, or Designee.

- (11) "Child" means an individual who is less than 18 years of age.
- (12) "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.
- (13) "Contracted In-Home Care Agency" means an incorporated entity or equivalent, licensed in accordance with OAR chapter 333, division 536 that provides hourly contracted in-home services to individuals receiving services through the Department or Area Agency on Aging.
- (14) "Cost Effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly alternatives when providing choices that adequately meet an individual's service needs. Those choices consist of all available service options, the utilization of assistive devices or assistive supports, natural supports, architectural modifications, and alternative service resources (defined in OAR 411-015-0005). Less costly alternatives may include resources not paid for by the Department.
- (15) "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. 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.
- (16) "Department" means the Department of Human Services.
- (17) "Designee" means an organization with which the Department contracts or has an interagency agreement.
- (18) "Developmental Disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.
- (19) "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 defined in OAR 411-015-0006.
- (20) "Division" means:
- (a) Oregon Health Authority, Addictions and Mental Health Division (AMHD);
  - (b) Department of Human Services, Aging and People with Disabilities Division (APD);
  - (c) Area Agencies on Aging (AAA);
  - (d) Department of Human Services, Self-Sufficiency Programs (SSP);
  - (e) Department of Human Services, Office of Developmental Disability Services (ODDS);
  - (f) Community Developmental Disability Programs (CDDP); and
  - (g) Support Services Brokerages.
- (21) "Fiscal Improprieties" means a homecare or personal support worker committed financial misconduct involving an individual's money, property, or benefits.
- (a) Fiscal improprieties include, but are not limited to, financial exploitation, borrowing money from an individual, taking an individual's property or money, having an individual purchase items for the homecare or personal support worker, forging an individual's signature, falsifying payment records, claiming payment for hours not worked, or similar acts intentionally committed for financial gain.
  - (b) Fiscal improprieties do not include the exchange of money, gifts, or property between a homecare or personal support worker whose employer is a relative unless an allegation of financial exploitation, as defined in OAR 411-020-0002 or OAR 407-045-0260, has been substantiated based on an adult protective services investigation.
- (22) "Guardian" means a parent for an individual less than 18 years of age or a person or agency appointed and authorized by the courts to make decisions about services for an individual.
- (23) "Homecare Worker" means a provider as described in OAR 411-031-0040, that is directly employed by an individual to provide either hourly or live-in services to the individual.
- (a) The term homecare worker includes:
    - (A) A consumer-employed provider in the Spousal Pay and Oregon Project Independence Programs;
    - (B) A consumer-employed provider that provides State Plan personal care services; and
    - (C) A relative providing Medicaid in-home services to an individual living in the relative's home.
  - (b) The term homecare worker does not include an Independent Choices Program provider or a personal support worker enrolled through Developmental Disability Services or the Addictions and Mental Health Division.
- (24) "Individual" means the person applying for or determined eligible for State Plan personal care services.
- (25) "Intellectual Disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.
- (26) "Lacks the Skills, Knowledge, and Ability to Adequately or Safely Perform the Required Work" means a homecare or personal support worker does not possess the skills to perform services needed by individuals receiving services from the Department. The homecare or personal support worker may not be physically, mentally, or emotionally capable of providing services to individuals. The homecare or personal support worker's lack of skills

may put individuals at risk because the homecare or personal support worker fails to perform, or learn to perform, the duties needed to adequately meet the needs of the individuals.

(27) "Legal Representative" means:

(a) For a child, the parent or step-parent unless a court appoints another person or agency to act as the guardian; and  
(b) For an adult:

(A) A spouse;

(B) A family member who has legal custody or legal guardianship according to ORS 125.005, 125.300, 125.315, and 125.310;

(C) An attorney at law who has been retained by or for an individual; or

(D) A person or agency authorized by the courts to make decisions about services for an individual.

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

(29) "Medicaid OHP Plus Benefit Package" means only the Medicaid benefit packages provided under OAR 410-120-1210(4)(a) and (b). This excludes individuals receiving Title XXI benefits.

(30) "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.

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

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

(33) "Personal Agent" means a person who is a case manager for the provision of case management services, works directly with individuals and the individuals' legal or designated representatives and families to provide or arrange for support services as described in OAR chapter 411, division 340, meets the qualifications set forth in OAR 411-340-0150, and is a trained employee of a support services brokerage or a person who has been engaged under contract to the brokerage to allow the brokerage to meet responsibilities in geographic areas where personal agent resources are severely limited.

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

(35) "Personal Support Worker" means:

(a) A provider:

(A) Who is hired by an individual with an intellectual or developmental disability or the individual's representative;

(B) Who receives money from the Department for the purpose of providing services to the individual in the individual's home or community; and

(C) Whose compensation is provided in whole or in part through the Department or community developmental disability program.

(b) This definition of personal support worker is intended to reflect the term as defined in ORS 410.600.

(36) "Provider" or "Qualified Provider" means a homecare worker or personal support worker that meets the qualifications in OAR 411-034-0050 that performs State Plan personal care services.

(37) "Provider Enrollment" means a homecare worker's or personal support worker's authorization to work as a provider employed by an eligible individual, representative, or legal representative for the purpose of receiving payment for services authorized by the Department. Provider enrollment includes the issuance of a Medicaid provider number.

(38) "Provider Number" means an identifying number issued to each homecare or personal support worker who is enrolled as a provider through the Department.

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

(40) "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.

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

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

(43) "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 monthly hours of personal care and supportive services authorized by the Department or the Department's designee.

(44) "Services Coordinator" means an employee of a community developmental disability program or other agency that contracts with the county or Department, who is selected to plan, procure, coordinate, and monitor an individual's plan for services, and to act as a proponent for individuals with intellectual or developmental disabilities.

(45) "State Plan Personal Care Services" means the assistance with personal care and supportive services described in OAR 411-034-0020 provided to an individual by a homecare worker or personal support worker. The assistance may include cueing, hands-on, monitoring, reassurance, redirection, set-up, standby, or support as defined in OAR 411-015-0005. The assistance may also require verbal reminding to complete one of the personal care tasks described in OAR 411-034-0020.

(46) "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.

(47) "Support Services Brokerage" means an entity, or distinct operating unit within an existing entity, that uses the principles of self-determination to perform the functions associated with planning and implementation of support services for individuals with intellectual or developmental disabilities.

(48) "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

#### **411-034-0030**

##### **Eligibility for State Plan Personal Care Services**

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

(a) Require assistance (defined in OAR 411-034-0010) from a qualified provider with one or more of the personal care tasks described in OAR 411-034-0020; and

(b) Be a current recipient of a Medicaid OHP Plus benefit package.

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

(a) The individual is receiving assistance with activities of daily living (as described in OAR 411-015-0006) from a licensed 24-hour residential services program (such as an adult foster home, assisted living facility, group home, or residential care facility);

(b) The individual is in a prison, hospital, sub-acute care facility, nursing facility, or other medical institution;

(c) The individual's service needs are met through the individual's natural support system (defined in OAR 411-034-0010); or

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

(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 are not intended to replace routine care commonly needed by an infant or child typically provided by the infant's or child's parent.

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

(6) The Department, Division, or Designee has the authority to close the eligibility and authorization for State Plan personal care services if an individual fails to:

(a) Employ a provider that meets the requirements in OAR 411-034-0050; or

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

(7) State Plan personal care services must not duplicate other Medicaid services.

Stat. Auth.: ORS 409.050 & 410.070

Stats. Implemented: ORS 409.010, 410.020, 410.070, 410.608, & 410.710

