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

CHAPTER 411
DIVISION 30

IN-HOME SERVICES

Table of Contents

411-030-0002 Purpose and Scope 1

411-030-0020 Definitions 1

411-030-0033 In-Home Service Living Arrangements 9

411-030-0040 Eligibility Criteria 11

411-030-0050 Case Management 15

411-030-0055 Community Transportation 19

411-030-0068 Live-In Services and Shift Services 20

411-030-0070 Maximum Hours of Service 24

411-030-0080 Spousal Pay Program 32

411-030-0090 Contracted In-Home Care Agency Services 34

411-030-0100 Independent Choices Program 34

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CHAPTER 411
DIVISION 30

IN-HOME SERVICES

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

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

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

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

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

411-030-0020 Definitions
(Amended 03/18/2016)

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

(7) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, or instrument of technology used to assist and enhance an individual's independence in performing any activity of daily living. Assistive devices include the use of service animals, general household items, or furniture to assist the individual.

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

(9) "CA/PS" means the "Client Assessment and Planning System" as defined in this rule.

(10) "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.

(11) "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.

(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) "Debilitating Medical Condition" means the individual's condition is severe, persistent, and interferes with the individual's ability to function and participate in most activities of daily living.

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

(19) "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.

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

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

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

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

(24) "Exception" means the following:

> (a) 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.
>
> (b) An approval for a live-in or shift care service plan granted to a specific individual that does not otherwise meet the criteria as

described in OAR 411-030-0068 based upon the service needs of the individual as determined by the Department.

(c) An approval of a service plan granted to a specific individual and a homecare worker to exceed the limitations as described in OAR 411-030-0070(6) based upon the service needs of the individual as determined by the Department.

(d) "Exceptional rate" or "exceptional payment." 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.

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

(26) "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.

(27) "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.

(28) "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.

(29) "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, not including live-in services.

(30) “Household” means a group of individuals that live together within the same dwelling. For homeless individuals, the household consists of the individuals who consider themselves living together.

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

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

(33) "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.

(34) "Individual" means a person age 65 or older, or an adult with a physical disability, applying for or eligible for services.

(35) "Individualized Back-Up Plan" means a plan incorporated into an Independent Choices Program service plan to address critical contingencies or incidents that pose a risk or harm to a participant's health and welfare.

(36) "In-Home Services" mean 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.

(37) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in IADL are identified in OAR 411-015-0007.

(38) "Liability" refers to the dollar amount an individual with excess income contributes to the cost of service pursuant to OAR 461-160-0610 and OAR 461-160-0620.

(39) "Live-In Services" mean services provided when an individual requires and receives assistance with activities of daily living and instrumental activities of daily living throughout a 24-hour work period by one homecare worker.

(40) "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.

(41) "Natural Supports" or "Natural Support System" means resources and supports (e.g. relatives, friends, neighbors, significant others, roommates, or the community) who are willing to voluntarily provide services to an individual without the expectation of compensation. Natural supports are identified in collaboration with the individual and the potential "natural support". The natural support is required to have the skills, knowledge, and ability to provide the needed services and supports.

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

(43) "Participant" means an individual eligible for the Independent Choices Program.

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

(45) "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.

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

(47) "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.

(48) "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.

(49) "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.

(50) "Shift Services" are hourly services provided by an awake homecare worker, Independent Choices Program employee provider, or contracted in-home care agency provider to an individual who is authorized to receive a minimum of 16 hours of services (496 hours per month) during a 24-hour work period. Individuals that have ventilator dependency and have quadriplegia or similar conditions and utilize 24 hours of awake hourly services (744 hours per month) may have homecare workers paid above the rate schedule.

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

(52) "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.

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

(54) "Workweek" is defined as 12:00 a.m. on Sunday through 11:59 p.m. on Saturday.

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

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

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

411-030-0033 In-Home Service Living Arrangements
(Amended 11/1/2013)

(1) The following terms are used in this rule:

(a) "Informal arrangement" means a paid or unpaid arrangement for shelter or utility costs that does not include the elements of a property manager's rental agreement.

(b) "Property manager's rental agreement" means a payment arrangement for shelter or utility costs with a property owner, property manager, or landlord that includes all of the following elements:

(A) The name and contact information for the property manager, landlord, or leaser;

(B) The period or term of the agreement and method for terminating the agreement;

(C) The number of tenants or occupants;

(D) The rental fee and any other charges (such as security deposits);

(E) The frequency of payments (such as monthly);

(F) What costs are covered by the amount of rent charged (such as shelter, utilities, or other expenses); and

(G) The duties and responsibilities of the property manager and the tenant, such as:

(i) The person responsible for maintenance;

(ii) If the property is furnished or unfurnished; and

(iii) Advance notice requirements prior to an increase in rent

(c) "Provider-owned dwelling" means a dwelling that is owned by a provider or the provider's spouse when the provider is proposing to be paid for Medicaid home and community-based services and the provider or the provider's spouse is not related to an individual by blood, marriage, or adoption. Provider-owned dwellings include, but are not limited to:

(A) Houses, apartments, and condominiums;

(B) A portion of a house such as basement or a garage even when remodeled to be used as a separate dwelling;

(C) Trailers and mobile homes; or

(D) Duplexes, unless the structure displays a separate address from the other residential unit and was originally built as a duplex.

(d) "Provider-rented dwelling" means a dwelling that is rented or leased by a provider or the provider's spouse when the provider is proposing to be paid for Medicaid home and community-based services and the provider or the provider's spouse is not related to an individual by blood, marriage, or adoption.

(2) An individual is eligible for Medicaid in-home services if the individual --

(a) Resides in a dwelling the individual owns or rents;

(b) Resides in a provider-owned or provider-rented dwelling and the individual's name is added to the property deed, mortgage, title, or property manager's rental agreement; or

(c) Resides, either through an informal arrangement or property manager's rental agreement, in a dwelling owned or rented by a relative as defined in OAR 411-030-0020.

(3) An individual is not eligible for Medicaid in-home services if the individual resides in a provider-owned or rented dwelling through an informal arrangement. A provider-owned or rented dwelling may meet the requirements for a limited adult foster home as described in OAR 411-050-0405.

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

411-030-0040 Eligibility Criteria
(Amended 04/03/2015)

(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) Meet all the eligibility requirements in 411-015-0010 through 411-015-0100; and(c) Reside in a living arrangement described in OAR 411-030-0033;

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

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

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

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

411-030-0050 Case Management
(Amended 11/1/2013)

(1) ASSESSMENT. The assessment process identifies an individual's ability to perform ADLs, IADLs, and determines an individual's ability to address health and safety concerns.

(a) The case manager must conduct an assessment in accordance with the standards of practices established by the Department in OAR 411-015-0008.

(b) The assessment must be conducted by a case manager or other qualified Department or AAA representative with a standardized assessment tool approved by the Department in the home of the eligible individual, no less than annually.

(2) PERSON-CENTERED SERVICE PLANNING.

(a) An individual and the individual's case manager, with the assistance of others involved, must consider in-home service options as well as assistive devices, architectural modifications, and other community-based resources to meet the service needs identified in the assessment process.

(A) The individual or the individual's representative is responsible for choosing and assisting in developing less costly service alternatives, including the Consumer-Employed Provider Program and contracted in-home care agency services.

(B) The case manager is responsible for --

(i) Determining eligibility for specific services;

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

(iii) Identifying risks;

(iv) Assisting the individual with developing backup plans;

(v) Identifying the individual’s goals and preferences;

(vi) Assessing the cost effectiveness of the individual's service plan; and

(vii) Developing a person-centered service plan.

(C) The case manager must monitor the service plan and make adjustments as needed.

(b) The Department takes necessary safeguards to protect an individual's health, safety, and welfare in implementing an individual's service plan in accordance with 42 CFR 441.302 and 42 CFR 441.570. When an individual with the ability to make an informed decision selects a service choice that jeopardizes health and safety, the Department or AAA staff shall offer or recommend options to the individual in order to minimize those risks. For the purpose of this rule, an "informed decision" means the individual understands the benefits, risks, and consequences of the service choice selected. Options that minimize risks may include offering or recommending:

(A) Natural supports to provide assistance with safety or health emergencies;

(B) An emergency response system;

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

(D) Resources for emergency disaster planning;

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

(F) Resources for provider and consumer training;

(G) Assistive devices; or

(H) Architectural modifications.

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

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

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

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

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

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

(D) The individual does not have the ability to make an informed decision, does not have a designated representative

to make decisions on his or her behalf, and the Department or AAA cannot take necessary safeguards to protect the safety, health, and welfare of the individual.

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

(3) PAYMENT.

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

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

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

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

(4) HARDSHIP SHELTER ALLOWANCE. The Department may not authorize a hardship shelter allowance associated with employing a live-in provider on or after June 1, 2006. Individuals eligible for and authorized to receive a hardship shelter allowance before June 1, 2006 may continue to receive a hardship shelter allowance on or after June 1, 2006 at the rate established by the Department if one of the following conditions is met:

(a) The individual is forced to move from their current dwelling and the individual's current average monthly rent or mortgage costs exceed current OSIP and OSIPM standards for a one-person need group as outlined in OAR 461-155-0250; or

(b) Service costs significantly increase as a result of the individual being unable to provide living quarters for a necessary live-in provider.

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

411-030-0055 Community Transportation
(Amended 11/1/2013)

(1) Community transportation (non-medical) may be prior-authorized for reasons related to an eligible individual's safety or health, in accordance with the individual's service plan. Community transportation is offered through contracted transportation providers or by homecare workers.

(2) Community transportation may be authorized to assist an eligible individual in getting to and from the individual's place of employment when the individual is approved for the Employed Persons with Disabilities Program (OSIPM-EPD).

(3) Natural supports, volunteer transportation, and other transportation services available to an eligible individual are considered a prior resource and may not be replaced with transportation paid for by the Department.

(4) DMAP is a resource for medical transportation to a physician, hospital, clinic, or other medical service provider. Medical transportation costs are not reimbursed through community transportation.

(5) Community transportation is not provided by the Department to obtain medical or non-medical items that may be delivered by a supplier or sent by mail order without cost to the eligible individual.

(6) Community transportation must be prior authorized by an individual's case manager and documented in the individual's service plan. The Department does not pay any provider under any circumstances for more than the total number of hours, miles, or rides prior authorized by the Department or AAA and documented in the individual's service plan.

(a) Contracted transportation providers are reimbursed according to the terms of their contract with the Department. Community

transportation services provided through contracted transportation providers must be authorized by a case manager based on an estimate of a total count of one way rides per month.

(b) Homecare workers who use their own personal vehicle for community transportation are reimbursed according to the terms defined in their Collective Bargaining Agreement between the Home Care Commission and Service Employees International Union, Local 503, OPEU. Any mileage reimbursement authorized to a homecare worker must be based on an estimate of the monthly maximum miles required to drive to and from the destination authorized in an individual's service plan. Community transportation hours are authorized in accordance with OAR 411-030-0070.

(c) The Department or AAA does not authorize reimbursement for travel to or from the residence of a homecare worker. The Department or AAA only authorizes community transportation and mileage from the home of an eligible individual to the destination authorized in the individual's service plan and back to the individual's home.

(7) The Department is not responsible for any vehicle damage or personal injury sustained while using a personal motor vehicle for community transportation.

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

411-030-0060 *(Repealed 6/7/2004 – Moved to OAR 411- 031)*

411-030-0065 *(Repealed 6/7/2004 – Moved to OAR 411- 031)*

411-030-0068 Live-In Services and Shift Services
(Temporary Effective 07/1/2016 to 12/27/2016)

(1) As of July 1, 2016, no individual may be approved to receive live-in services who did not receive live-in services on June 30, 2016.

(2) An individual is only eligible for shift services if the assessment determines the individual meets the criteria described in section (3) of this rule.

(3) Individuals with service plans that meet the definition of live-in services or shift services must meet subsections (a) and either (b) or (c) of this section of the rule.

(a) The provision of assistance with at least one ADL or IADL task must be required sometime during each hour the individual is awake in order to ensure the safety and well-being of the individual.

(b) The individual is assessed as full assist in mobility or elimination as defined in OAR 411-015-0006, and has at least one of the following conditions:

(A) A debilitating medical condition that includes, but is not limited to, any of the following symptoms:

(i) Cachexia;

(ii) Severe neuropathy;

(iii) Coma;

(iv) Persistent or reoccurring stage 3 or 4 wounds;

(v) Late stage cancer;

(vii) Frequent and unpredictable seizures; or

(viii) Debilitating muscle spasms.

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

(C) An acute care or hospice need that is expected to last no more than six months.

(c) The individual is assessed as full assist in cognition as defined in OAR 411-015-0006 and meets all of the following criteria:

(A) A diagnosis of traumatic brain injury, dementia or a related disorder, or a debilitating mental health disorder that meets the criteria described in OAR 411-015-0015(2); and

(B) Has one of the following assessed needs as defined in OAR 411-015-0006:

(i) Full assist in danger to self or others.

(ii) Full assist in wandering.

(iii) Full assist in awareness.

(iv) Full assist in judgment.

(4) The following limitations apply:

(a) A homecare worker providing live-in services must be available to address the service needs of an eligible individual as they arise throughout an entire 24-hour period. A homecare worker is not providing live-in services if the homecare worker is outside the individual's home or building during the homecare worker's on-duty hours and the homecare worker engages in activities that are unrelated to the provision of the individual's ADL or IADL services and supports. A homecare worker is not providing live-in services if they are offsite and are not performing direct ADL or IADL services.

(b) Hourly services by another homecare worker or contracted in-home agency may be authorized in addition to live-in services for any task that requires more than one homecare worker to simultaneously perform the task, or to allow a live-in homecare worker to sleep for at least five continuous hours during a 24-hour work period.

(c) A homecare worker who is providing live-in services for an individual may not also provide hourly services for the same individual.

(5) Individuals who are receiving live-in services on June 30, 2016 may continue receiving live-in services until one of the following occurs:

(a) The individual moves from an in-home setting that does not meet the requirements of OAR 411-030-0033 for more than 30 days and later moves to an in-home setting that meets the requirements of OAR 411-030-0033.

(b) The individual ends his or her live-in services for more than 30 days.

(c) An assessment determines the individual does not meet the criteria described in section (3) of this rule.

(6) Individuals who currently receive live-in services for at least four days a week, or are receiving hours under live-in services in the Independent Choices Program, and who have been determined not to meet the criteria for live-in services per section (1) of this rule after an assessment created on or after August 31, 2015, may be granted an exception by central office under the following circumstances:

(a) The individual must be eligible for 159 hours of live-in services on the most recent assessment prior to August 31, 2015, and be assessed as meeting one of the following as defined in OAR 415-015-0006:

(A) Full assist in mobility and at least a substantial assist in ambulation or an assist in transfers.

(B) Full assist in cognition.

(C) Full assist in at least two ADLs under elimination.

(b) Exceptions granted under subsection (a) of this rule must end when the identified homecare worker per subsection (a) of this rule or the primary provider under the Independent Choices Program is no longer employed by the individual.

(7) An individual may employ homecare workers with a differential rate in accordance with the terms of the ratified collective bargaining agreement described in OAR 411-031-0020, if the following applies:

(a) The individual is diagnosed with quadriplegia or a condition that is substantially similar;

(b) The individual is dependent on a ventilator;

(c) The individual is eligible for and receives shift services;

(d) Within a 24-hour work period, the individual requires at least 16 hours of paid shift care and up to 8 hours of unpaid care; and

(e) The plan is approved by the Department.

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

411-030-0070 Maximum Hours of Service
(Temporary Effective 07/1/2016 to 12/27/2016)

(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 and 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 and Behaviors:

(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 the rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for ADLs paid at the rates in accordance with the rate schedule. Participants of the Independent Choices Program may determine their own employee provider pay rates, but must follow all applicable wage and hour rules and regulations.

(3) MAXIMUM 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:

(I) Breakfast, 4 hours;

(II) Lunch, 4 hours;

(III) Supper, 8 hours.

(ii) Substantial assistance:

(I) Breakfast, 8 hours;

(II) Lunch, 8 hours;

(III) Supper, 16 hours.

(iii) Full assistance:

(I) Breakfast, 12 hours;

(II) Lunch, 12 hours;

(III) Supper, 24 hours.

(D) Shopping:

(i) Minimal assistance, 2 hours;

(ii) Substantial assistance, 4 hours;

(iii) Full assistance, 6 hours.

(E) Housecleaning:

(i) Minimal assistance, 5 hours.

(ii) Substantial assistance, 10 hours.

(iii) Full assistance, 20 hours.

(b) Hours authorized for IADL are paid at the rates in accordance with the rate schedule. The Independent Choices Program cash benefit is based on the hours authorized for IADLs paid at the rates in accordance with the rate schedule. Participants of the Independent Choices Program may determine their own employee provider pay rates, but must follow all applicable wage and hour rules and regulations.

(c) When two or more individuals eligible for IADL task hours live in the same household, the assessed 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) PAYMENT FOR LIVE-IN SERVICES.

(a) Payment for live-in services is authorized only when an individual employs a live-in homecare worker or enrolls in the Independent Choices Program and meets the requirements of OAR 411-030-0068.

(b) Effective January 1, 2016, payment for live-in services is authorized only when an individual employs a live-in homecare worker or enrolls in the Independent Choices Program and meets the requirements of OAR 411-030-0068. Individuals that meet these criteria will be authorized to receive at least 16 hours per day (496 hours per month). Additional hours may be authorized by the Department to meet the needs of the individual during the hours of the homecare worker's scheduled sleep period if the homecare worker's scheduled sleep period is routinely disrupted.

(c) Rates for live-in services are paid in accordance with the rate schedule.

(d) When a live-in homecare worker is employed less than seven days per week, the total service hours must be prorated.

(5) When one or more eligible individuals in the same household is eligible for and receiving in-home services, the amount of hours authorized is subject to the following maximums:

(a) If any eligible individual in a specific household is receiving live-in services, the combined authorized hours for all eligible individuals in the same household may not exceed 19 hours within any 24-hour period or 589 hours per month.

(b) Hourly and shift service plans may not exceed 24 hours within any 24-hour period or 744 hours per month in the same household.

(6) Beginning July 1, 2016, when a homecare worker begins employment with an individual, the following limitations to the authorized hours a homecare worker may work will apply:

(a) Hourly or shift service plans of no more than 220 hours per month, not to exceed 50 hours per workweek per individual.

(b) Hourly or shift services plan of no more than 16 hours of awake care during a 24-hour work period.

(7) 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.

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

(9) 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.

(10) 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 live-in services. Services must be authorized to meet the needs of an eligible individual and may not be provided to benefit an entire household.

(11) 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) As long as the total number of IADL task hours in the service plan does not exceed 85 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.

(d) Monthly service plans that exceed 85 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.

(e) One or more individuals in the same household may exceed the maximums in section (5) of this rule in the following circumstances:

(A) The service plan authorizes payment that requires the assistance of more than one homecare worker to simultaneously perform a specific task.

(B) The service plan authorizes an additional hourly provider when the individual requires care throughout a 24 hour period and the live-in homecare worker is not able to receive five continuous hours of sleep.

(C) The ADLs of two or more individuals in the same household require a homecare worker for each individual at the same time.

(f) A homecare worker may be authorized to provide services totaling more than 176 hours per month or 40 hours per workweek if they are prior authorized by the Department. In emergency situations, when the Department is not available, a homecare worker may work critical hours, but must notify the Department within two business days.

(g) A homecare worker may be authorized by the Department to work more than 16 hours of hourly services during a 24-hour work period if an unanticipated need arises that requires the homecare worker to remain awake in order to provide the necessary care.

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

411-030-0080 Spousal Pay Program
(Amended 03/18/2016)

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

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

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

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

(c) The individual has met all eligibility requirements as described in OAR 411-030-0068(1)(b).

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

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

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

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

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

(3) PAYMENTS.

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

(b) The hours authorized to the spousal pay provider in an individual's service plan must consist of one-half of the assessed hours for IADLs and all of the hours for specific ADLs based on the service needs of the individual. Service plans that authorize a spousal pay provider are not eligible for live-in services.

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

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

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

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

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

(6) All Spousal Pay Program service plans with live-in hours in effect before January 1, 2016 will transition to hourly plans by January 1, 2016.

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

411-030-0090 Contracted In-Home Care Agency Services
(Amended 11/1/2013)

(1) Contracted in-home care agency services are one of the in-home service options for individuals eligible for Medicaid in-home services.

(2) In-home care agencies must be licensed in accordance with OAR chapter 333, division 536. The geographic service area in which the agency provides services must comply with OAR 333-536-0050. The specific services provided must be described in each contracted in-home care agency's statement of work.

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

411-030-0100 Independent Choices Program
(Amended 03/18/2016)

(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 eligible individuals' names on the waiting list according to the date the individual applied for participation in ICP.

(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 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 any of the following ICP responsibilities:

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

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

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

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

(C) Failure to purchase 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.

(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 live-in service needs.

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

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

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

(7) CASH BENEFIT.

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

(b) The cash benefit is calculated by adding the ADL task hours, the IADL task hours, and the live-in services 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 or AAA case manager.

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

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

(9) CONTINGENCY FUND.

(a) The participant may establish a contingency fund in the service budget to purchase identified items that are not otherwise covered by 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 or 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.

(14) ICP eligible participants who were determined eligible before August 31, 2015 may continue his or her current service plan until a new assessment and service plan is completed.

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