

**DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES**

**CHAPTER 411
DIVISION 375**

**INDEPENDENT PROVIDERS DELIVERING DEVELOPMENTAL
DISABILITIES SERVICES**

411-375-0000 Purpose
(Amended 06/29/2016)

(1) The rules in OAR chapter 411, division 375 establish the standards and procedures governing independent providers and the fiscal services provided on behalf of individuals who employ or contract with an independent provider.

(2) Independent providers provide home and community-based waiver, state plan, and general fund services to individuals eligible for developmental disabilities services and receiving supports authorized by a case management entity.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0010 Definitions and Acronyms
(Amended 06/29/2016)

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 375.

(1) "Active Provider Number" means an identifying number that is issued by the Department to an independent provider after the independent provider completes the qualification and enrollment conditions as described in OAR 411-375-0020. An active provider number is a provider number that is not currently in inactivated or terminated status.

(2) "ADL" means "activities of daily living".

(3) "Base Pay Rate" means the hourly wage to be paid to personal support workers, without any differentials, established in the Collective Bargaining Agreement.

(4) "Behaviorally-Driven Services and Supports" means the behavioral treatments identified in a functional needs assessment that an individual requires in addition to routine assessed ADL and IADL supports.

(5) "Burden of Proof" means that the existence or nonexistence of a fact is established by a preponderance of the evidence.

(6) "CDDP" means "Community Developmental Disability Program".

(7) "CIIS" means "Children's Intensive In-Home Services".

(8) "Collective Bargaining Agreement" means the Collective Bargaining Agreement between the Home Care Commission and the Service Employees International Union, Local 503, Oregon Public Employees Union regarding wages, hours, rules, and working conditions.

(9) "Common Law Employer" means a person responsible for the management of personal support workers in their duties described in these rules. Common law employers are also known as an employer of record (EOR).

(10) "Common Law Employer Proxy" means a person who is delegated specific tasks to assist a common law employer in the duties of a common law employer.

(11) "Community Transportation" means the ancillary service described in OAR 411-435-0050 that enables an individual to gain access to community-based state plan and waiver services, activities and resources that are not medical in nature. Community transportation is provided in the area surrounding the home of the individual that is commonly used by people in the same area to obtain ordinary goods and services. Community transportation is available through the Community First Choice State Plan Amendment.

(12) "Confidentiality" means the conditions for use and disclosure of specific information governed by other laws and rules including, but not limited to, OAR 407-014-0000 to 407-014-0070 (Privacy of Protected Information).

(13) "Department Funds" means state public funds or Medicaid funds used to purchase developmental disabilities services for individuals enrolled in services as defined in this rule.

(14) "Enhanced Personal Support Worker" means a personal support worker who is certified by the Home Care Commission to provide services for individuals who require advanced medically or behaviorally-driven services and supports as defined and assessed through a functional needs assessment tool.

(15) "Evidence" means testimony, writings, material objects, or other things presented to the senses that are offered to prove the existence or nonexistence of a fact.

(16) "Exceptional Personal Support Worker" means a personal support worker who is certified by the Home Care Commission to provide services for individuals who require extensive medically or behaviorally-driven services and supports as assessed by a functional needs assessment tool and whose service needs also require staff to be awake more than 20 hours in a 24-hour period.

(17) "eXPRS" means "Express Payment and Reporting System". eXPRS is the Department's information system that tracks and documents service delivery of claims funded by the Department.

(18) "Failure to Act as a Mandatory Reporter" means that a personal support worker has reasonable cause to believe that the abuse of a child, an older adult, adult with an intellectual or developmental disability or mental illness, or a resident of a nursing facility has occurred, but fails to report the suspected abuse as required by ORS 419B.015, ORS 124.065, ORS 430.743, or ORS 441.645.

(19) "Failure to Provide Services as Required" means an independent provider does not provide services to an individual as described in the service agreement.

(20) "FICA" means "Federal Insurance Contributions Act".

(21) "Fiscal Improprieties" means financial misconduct involving the money, property, or benefits of an individual.

(a) Fiscal improprieties include, but are not limited to, financial exploitation, borrowing money from an individual, taking property or money from an individual, having an individual purchase items for the independent provider, forging the signature of an individual, falsifying payment records, claiming payment for hours not worked, repeatedly claiming payment for hours not prior authorized, or similar acts intentionally committed for financial gain.

(b) Fiscal improprieties do not include the exchange of money, gifts, or property between a personal support worker and an individual with whom the personal support worker is related 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) "Fiscal Intermediary" means a person or entity that receives and distributes Department funds on behalf of an individual who employs or contracts with a personal support worker to provide services.

(23) "IADL" means "instrumental activities of daily living".

(24) "Imminent Danger" means there is reasonable cause to believe the life or physical, emotional, or financial well-being of an individual is in danger if no intervention is immediately initiated.

(25) "Inactivation" means an independent provider has a Department issued provider number that has been inactivated in accordance with OAR 411-375-0070(1) or OAR 411-375-0070(2).

(26) "Independent Provider" means a personal support worker, a person who is paid as a contractor, or a self-employed person. An agency or the employee of an agency is not an independent provider.

(27) "ISP" means "Individual Support Plan".

(28) "Lack of Skills, Knowledge, or Ability to Adequately or Safely Provide Services" means an independent provider does not possess the skills to perform services as defined in this rule. The independent provider is not physically, mentally, or emotionally capable of providing services and the lack of skills puts an individual at risk because the independent provider fails to perform, or learn to perform, the duties needed to adequately meet the needs of the individual.

(29) "Medically-Driven Services and Supports" means the medical treatments identified in a functional needs assessment that an individual requires in addition to routine assessed ADL and IADL supports.

(30) "Office of Administrative Hearings" means the office described in ORS 183.605 established within the Employment Department to conduct contested case proceedings on behalf of designated state agencies.

(31) "Personal Support Worker":

(a) Means a person:

(A) Who has a Medicaid provider number;

(B) Hired by an individual with an intellectual or developmental disability or the representative of the individual;

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

(D) Whose compensation for providing services is provided in whole or in part through a case management entity.

(b) This definition of personal support worker is intended to be interpreted consistently with ORS 410.600.

(32) "Preponderance of the Evidence" means that one party's evidence is more convincing than the other party's evidence in a contested case hearing.

(33) "Protective Service and Abuse Rules" mean the rules described in OAR chapter 411, division 020, OAR chapter 407, division 045, OAR chapter 413, division 015, and OAR chapter 943, division 045.

(34) "Provider Enrollment" means the process for enrolling an independent provider for the purpose of receiving payment for authorized services provided to an individual. Provider enrollment includes the completion and submission of a Provider Enrollment Agreement before receiving a provider number.

(35) "Provider Number" means the identifying number issued to a qualified independent provider.

(36) "Restricted Personal Support Worker" means the Department or the designee of the Department has placed restrictions on the provider enrollment of a personal support worker as described in OAR 411-375-0020.

(37) "Termination" means an independent provider has a Department issued provider number that has been terminated in accordance with OAR 411-375-0070(3).

(38) "Travel Directly" means that a personal support worker's travel from one individual's home or service setting to another individual's home or service setting is not interrupted for reasons other than to eat a meal, purchase fuel for the vehicle being used for the travel, use a restroom, or change buses, trains, or other modes of public transit.

(39) "These Rules" mean the rules in OAR chapter 411, division 375.

(40) "Unacceptable Conduct at Work" means an independent provider has repeatedly engaged in one or more of the following behaviors:

(a) Delay in arrival to work or absence from work not prior-scheduled with an individual that is either unsatisfactory to the individual or neglects the individual's service needs; or

(b) Inviting unwelcome guests or pets into an individual's home, resulting in the individual's dissatisfaction or a personal support worker's inattention to the individual's required service needs.

(41) "Violation of a Drug-Free Workplace" means there was a credible complaint against an independent provider for:

(a) Being intoxicated by alcohol, inhalants, prescription drugs, or other drugs, including over-the-counter medications, while:

(A) Responsible for the care of an individual;

(B) In the individual's home; or

(C) Transporting the individual.

(b) Manufacturing, possessing, selling, offering to sell, trading, or using illegal drugs while providing authorized services to an individual or while in the individual's home.

(42) "Violation of Protective Service and Abuse Rules" means, based on a substantiated allegation of abuse, an independent provider was found to have violated the protective service and abuse rules described in OAR chapter 411, division 020, OAR chapter 407, division 045, OAR chapter 413, division 015, or OAR chapter 943, division 045.

(43) "Workday" means 12:00 AM through 11:59 PM.

(44) "Work Week" means 12:00 AM Sunday through 11:59 PM Saturday.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0020 Independent Provider Enrollment and Qualifications
(Amended 06/29/2016)

(1) INDEPENDENT PROVIDER QUALIFICATIONS: An independent provider who is qualified to provide services must:

(a) Be at least 18 years of age.

(b) Have approval to work based on a background check completed by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (3) of this rule.

(c) Not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275 unless hired or contracted with prior to July 28, 2009 and remaining in the original position for which the independent provider was hired or contracted.

(d) Be free of convictions, founded allegations of abuse, or substantiated allegations of abuse by the appropriate agency including, but not limited to, the Department or case management entity.

(e) Be legally eligible to work in the United States.

(f) Demonstrate by background, education, references, skills, and abilities that the independent provider is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by the individual, or their legal or designated representative including:

(A) Ability and sufficient education to follow oral and written instructions and keep any required records;

(B) Possess the physical health, mental health, good judgment, and good personal character determined necessary to provide services;

(C) Ability to communicate with the individual; and

(D) Training of a nature and type sufficient to ensure that the independent provider has knowledge of emergency procedures specific to the individual.

(g) Maintain confidentiality and safeguard individual information. Unless given specific permission by an individual or the legal representative of an individual, the independent provider may not share any personal information about the individual including medical,

social service, financial, public assistance, legal, or other personal details.

(h) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General (<http://exclusions.oig.hhs.gov/>).

(i) Complete and submit a Provider Enrollment Agreement to the Department and possess a current provider number issued by the Department.

(j) Have a tax identification number or Social Security number that matches the legal name of the independent provider as verified by the Internal Revenue Service or Social Security Administration.

(k) If providing services requiring professional licensure, possess a current and unencumbered license. The individual the designated or legal representative of the individual, or the case management entity must check the license status to verify the license is current and unencumbered.

(l) If transporting an individual, have a valid license to drive and proof of insurance, as well as any other license or certification that may be required under state and local law depending on the nature and scope of the transportation. Copies of these documents must be available to any case management entity that authorizes community transportation upon authorization and as requested.

(m) An independent provider must meet the qualifications for a provider as described in the Oregon Administrative Rules that are relevant to the specific service when applicable.

(2) INDEPENDENT PROVIDER EXCLUSIONS. An independent provider may not be authorized to provide services to an individual if:

(a) The independent provider is the parent of the individual if the individual is less than 18 years of age;

(b) The independent provider is the legal representative of the individual who has not appointed a designated representative to plan supports for the individual;

(c) The independent provider is the designated representative of the individual;

(d) The independent provider is the spouse of the individual; or

(e) The independent provider is the common law employer or common law employer proxy for the individual.

(3) BACKGROUND CHECKS.

(a) A subject individual as defined in OAR 407-007-0210 may be approved for one position to work statewide when the subject individual is working in the same employment role with the same population. The Background Check Request Form must be completed by the subject individual to show intent to work statewide.

(b) When an independent provider is approved without restrictions following a background check fitness determination, the approval must meet the provider enrollment requirements for the employment role of the independent provider.

(c) If an independent provider has been approved under OAR 407-007-0200 to 407-007-0370 on a background check submitted to the Department between July 1, 2012 and June 30, 2014, the independent provider may use that approval notice to work statewide with the same population until a new background check is needed. Statewide clearance does not apply to a restricted personal support worker.

(d) Background check approval is effective for two years from the date of fitness determination to provide services except in the following circumstances:

(A) A new fitness determination is conducted resulting in a change in approval status; or

(B) The Department has terminated the provider enrollment for the independent provider.

(e) The case management entity may conduct a background recheck more frequently based on:

(A) Additional information discovered about the independent provider, such as possible criminal activity or other allegations;
or

(B) At the request of the individual or designated common law employer. Upon request, the personal support worker must provide any additional info to complete the updated background recheck within 30 days.

(f) An independent provider must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and OAR 407-007-0290 to the case management entity within 24 hours.

(4) The Department may not complete provider enrollment in the following circumstances:

(a) The applicant has been suspended or terminated as a provider by another division within the Department or the Oregon Health Authority;

(b) The applicant has a history of violating protective service and abuse rules or has a founded report of child abuse or substantiated adult abuse;

(c) The applicant has committed fiscal improprieties;

(d) The applicant has demonstrated a lack of skills, knowledge, or ability to adequately or safely provide services;

(e) The applicant has an unacceptable background check or the background check results in a closed case pursuant to OAR 407-007-0325;

(f) The applicant is on the list of excluded or debarred providers maintained by the Office of the Inspector General (<http://exclusions.oig.hhs.gov/>);

(g) The case management entity has documentation the applicant is not capable of performing required services in a professionally competent, safe, legal, or ethical manner; or

(h) The tax identification number or Social Security number for the applicant does not match the legal name of the applicant as verified by the Internal Revenue Service or Social Security Administration.

(5) A personal support worker must attend a personal support worker orientation consistent with the Collective Bargaining Agreement.

(6) RESTRICTED PERSONAL SUPPORT WORKER PROVIDER ENROLLMENT.

(a) The Department may enroll an applicant as a restricted personal support worker. A restricted personal support worker may only provide services to a specific individual who is a family member, neighbor, or friend.

(A) After conducting a weighing test as described in OAR 407-007-0200 to 407-007-0370, the Department may approve a restricted enrollment for an applicant with a prior criminal record, unless under OAR 407-007-0275 the applicant has been found ineligible due to ORS 443.004.

(B) The Department may approve a restricted enrollment for an applicant based on the lack of skills, knowledge, or ability of the applicant to adequately or safely provide services.

(b) To remove restricted personal support worker status, the applicant must complete a new application and background check and be approved by the Department.

(7) ENHANCED AND EXCEPTIONAL PERSONAL SUPPORT WORKERS.

(a) ENHANCED PERSONAL SUPPORT WORKERS.

(A) A personal support worker must be certified by the Home Care Commission as an enhanced personal support worker to provide services for individuals who require advanced medically

or behaviorally-driven services and supports as assessed by a functional needs assessment.

(B) Enhanced personal support workers are paid for providing ADL and IADL services at the enhanced personal support worker rate set forth in the Collective Bargaining Agreement. The enhanced personal support worker rate is effective the first day of the month following the month in which both:

(i) The personal support worker is certified by the Oregon Home Care Commission to provide services; and

(ii) The outcome of the individual's functional needs assessment indicates the need for assistance with advanced medically or behaviorally-driven services.

(b) EXCEPTIONAL PERSONAL SUPPORT WORKER.

(A) A personal support worker must be certified by the Home Care Commission as an exceptional personal support worker to provide services for individuals who require assistance with extensive medically or behaviorally-driven services and supports as assessed by a functional needs assessment.

(B) Exceptional personal support workers are paid for providing ADL and IADL services at the exceptional personal support worker rate set forth in the Collective Bargaining Agreement. The exceptional personal support worker rate is effective the first day of the month following the month in which both:

(i) The personal support worker is certified by the Oregon Home Care Commission to provide services; and

(ii) The outcome of the individual's functional needs assessment indicates the need for assistance with extensive medically or behaviorally-driven services and at least 20 hours per day of attendant care support excluding 2:1 support hours.

(c) A personal support worker who has been certified by the Oregon Home Care Commission to provide enhanced or exceptional supports may not receive the enhanced or exceptional rate when providing services to an individual whose functional needs assessment does not indicate the need for assistance with advanced or extensive medically or behaviorally-driven services except as required by the Collective Bargaining Agreement.

(8) INDEPENDENT PROVIDER CONTINUED ENROLLMENT RESPONSIBILITIES.

(a) An independent provider is responsible for maintaining an active provider number by:

(A) Completing and submitting a new Provider Enrollment Agreement to the Department at least 55 calendar days prior to the end date of the agreement; and

(B) Completing and submitting a Background Check Request Form and receiving approval to work by the Department at least 55 calendar days prior to the end of the background check approval period.

(b) An independent provider is responsible to attend trainings and maintain certifications as required by applicable program rules.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0030 Personal Support Worker-Individual Relationship
(Repealed 06/29/2016)

411-375-0035 Documentation and Reporting Requirements
(Adopted 06/29/2016)

(1) SERVICE AGREEMENT.

(a) An independent provider may not provide services to an individual without a completed and authorized Service Agreement.

(b) An independent provider must maintain a copy of the authorized Service Agreement for the authorized service period.

(c) For personal support workers, the Service Agreement serves as a job description.

(d) For independent providers who are not personal support workers, the independent provider's signature on the individual's ISP may serve as the Service Agreement.

(2) PROGRESS NOTES.

(a) Independent providers must maintain regular progress notes. The progress note must include, at minimum, the following information regarding the service rendered:

(A) Date and time the service was provided; and

(B) Information regarding progress towards achieving the intended ISP goal identified in the Service Agreement for which the service was delivered.

(b) For a personal support worker, progress notes must be submitted to the case management entity upon request from the case management entity and with a timesheet as part of the claim for payment.

(c) For an independent provider who is not a personal supportworker, progress notes must be submitted as required by applicable program rules.

(3) INCIDENT REPORTING.

(a) Independent providers must notify the individual's case management entity of any injury, accident, act of physical aggression, or unusual incident involving an individual.

(b) Independent providers must notify the individual's case management entity of any reasonable suspicion that an individual is the victim of abuse.

(c) Independent providers who are mandatory reporters must also make reports of suspected abuse consistent with ORS 419B.015, ORS 124.065, ORS 430.743, or ORS 441.645.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0040 Fiscal and Accountability Responsibility

(Amended 06/29/2016)

(1) DIRECT SERVICE PAYMENTS. The case management entity or contracted fiscal intermediary makes payment to an independent provider on behalf of an individual for all services.

(a) Payment is considered full payment for the services rendered. The independent provider may not, under any circumstances, demand or receive additional payment for Department-funded services from the individual or any other source.

(b) The Department only makes payment for services that --

(A) Are authorized in an ISP, and included in a Service Agreement;

(B) The provider has been authorized in eXPRS to deliver the service; and

(C) The provider has delivered the service.

(c) The Department does not make Department funds available to an individual or common law employer to pay an independent provider.

(d) The Department only makes payment to an enrolled provider who actually performs the authorized services. Federal regulations prohibit the Department from making payment to a collection agency.

(e) All Department funds paid to a personal support worker must come through a fiscal intermediary.

(2) **TIMELY SUBMISSION OF CLAIMS.** In accordance with 42 CFR 447.45, all claims for services must be submitted within 12 months from the date of services in order to be considered for payment. A claim submitted after 12 months from the date of services may not be considered for payment.

(3) **CLAIM OR ENCOUNTER SUBMISSION.**

(a) Submission of a claim, encounter, or other payment request document constitutes the agreement of an independent provider that:

(A) The services were provided in compliance with the Service Agreement in effect on the date of service;

(B) The information on the claim, encounter, or other payment request document, regardless of the format, is true, accurate, and complete; and

(C) The independent provider understands that payment of the claim, encounter, or other payment request document is from Department funds and that any falsification or concealment of a material fact may result in prosecution under federal and state laws.

(b) The independent provider must submit a claim for payment directly into eXPRS, unless an exception has been granted by the case management entity.

(A) Claims for payment submitted by independent providers who are not personal support workers must include documentation from the provider of services delivered.

(B) Claims for payment submitted by personal support workers must meet the requirements of a properly completed timesheet as defined by the Collective Bargaining Agreement including submission of progress notes as required by this rule.

(4) CLAIM OR ENCOUNTER AUTHORIZATION. Authorization of a submitted claim, encounter, or other payment request document by the employer, constitutes agreement that the independent provider provided services in accordance with the claim.

(5) INDEPENDENT PROVIDER PAYMENT LIMITATIONS.

(a) Department funds may not pay for services delivered by an independent provider who does not possess an active provider number issued by the Department on the date services are delivered.

(b) An active provider number with the Department is not a guarantee that an independent provider shall receive any minimum amount of work or payment from the case management entity.

(c) Payment is not made for services delivered to any individual prior to:

(A) The return of a signed Service Agreement, specific to the individual, to the case manager of the individual.

(i) When the provider is a personal support worker, a completed Service Agreement must include a dated signature from the common law employer and the personal support worker.

(ii) When the provider is an independent provider, but not a personal support worker, a completed Service Agreement must include the name and dated signature of the individual or the representative of the individual.

(B) Authorization of the services in eXPRS.

(d) A personal support worker may not work more than 50 hours in a work week, per individual, unless:

(A) The personal support worker is delivering daily relief care;
or

(B) An exception has been granted by the case management entity. All determinations regarding exceptions to the 50 hour limitation are final.

(e) A personal support worker may not work more than 40 hours in a work week for any one child in a CIIS program.

(6) ANCILLARY CONTRIBUTIONS FOR PERSONAL SUPPORT WORKERS.

(a) FICA. Acting on behalf of the individual, the case management entity or contracted fiscal intermediary shall apply any applicable FICA regulations including:

(A) Withholding the FICA contribution of the personal support worker from the payment to the personal support worker; and

(B) Submitting the FICA contribution of the individual and the amounts withheld from the payment to the personal support worker to the Social Security Administration.

(b) BENEFIT FUND ASSESSMENT. The Workers' Benefit Fund pays for programs that provide direct benefits to an injured worker and the beneficiary of the injured worker and also assists an employer in helping an injured worker return to work. The Department of Consumer and Business Services sets the Workers' Benefit Fund assessment rate for each calendar year. The case management entity or contracted fiscal intermediary calculates the hours rounded up to the nearest whole hour and deducts an amount rounded up to the nearest cent. Acting on behalf of the individual, the case management entity or contracted fiscal intermediary:

(A) Deducts the share of the Benefit Fund assessment rate for the personal support worker for each hour or partial hour worked;

(B) Collects the share of the Benefit Fund assessment rate for the individual for each hour or partial hour of paid services received; and

(C) Submits the contributions of the personal support worker and the individual to the Workers' Benefit Fund.

(c) The case management entity or contracted fiscal intermediary submits the unemployment tax.

(7) STATE AND FEDERAL INCOME TAX WITHHOLDING.

(a) The case management entity or contracted fiscal intermediary withholds state and federal income taxes on all payments to personal support workers as indicated in the Collective Bargaining Agreement.

(b) Personal support workers must complete and return a current Internal Revenue Service (IRS) W-4 form.

(A) Personal support workers working with individuals receiving services through a CDDP or Support Services Brokerage must return all applicable IRS forms to the local office of the CDDP or Support Services Brokerage.

(B) Personal support workers working with individuals receiving services through CIIS must return the IRS forms to the Central Office of the Department.

(C) The case management entity or contracted fiscal intermediary must apply standard income tax withholding practices in accordance with 26 CFR 31.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0045 Overpayments

(Amended 06/29/2016 - language moved from OAR 411-375-0060)

(1) An overpayment is any payment made by the Department or case management entity to an independent provider that is more than the independent provider is permitted to receive under DHS rules. An independent provider may only receive payment for a number of hours that are actually provided and do not exceed the amount stated in a Service Agreement.

(2) Overpayments are categorized as follows:

(a) ADMINISTRATIVE ERROR. The case management entity failed to authorize, compute, or process the correct amount of service hours or wage rate.

(b) INDEPENDENT PROVIDER ERROR. The Department overpays the independent provider due to a misunderstanding or unintentional error.

(c) FRAUD. "Fraud" means taking actions that may result in the independent provider receiving a benefit in excess of the correct amount whether by intentional deception, misrepresentation, or failure to account for payments or money received. "Fraud" also means spending payments or money the independent provider was not entitled to and any act that constitutes fraud under applicable federal or state law (including 42 CFR 455.2). The Department of Justice, Medicaid Fraud Unit determines when a Medicaid fraud allegation is pursued for prosecution.

(3) The Department may recover an overpayment established by a judgment in a state or federal court, by the Department or another administrative agency in a contested case proceeding, or by a signed document in which the person acknowledges the overpayment and waives the right to a contested case hearing.

(4) Overpayments for personal support workers are recovered as follows:

(a) Overpayments are collected prior to garnishments, such as child support, Internal Revenue Service back taxes, or educational loans.

(b) Overpayments due to administrative error or personal support worker error are recouped at no more than five percent of the total for the hours paid until repaid in full.

(c) When a fraud overpayment has occurred, the Department shall determine the manner and the amount to be recovered.

(d) When a provider is no longer employed as a personal support worker, any remaining overpayment is deducted from the final check to the provider. The provider is responsible for repaying the amount in full when the final check is insufficient to cover the remaining overpayment.

(3) Overpayments for independent providers who are not personal support workers are recovered as described in OAR chapter 407, division 120.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0050 Personal Support Worker Benefits and Secondary Expenses

(Amended 06/29/2016)

(1) The only benefits available to personal support workers are negotiated in the Collective Bargaining Agreement and provided in Oregon Revised Statute. The Collective Bargaining Agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Personal support workers are not employees of a case management entity.

(2) Workers' compensation, as defined in Oregon Revised Statute, is available to eligible personal support workers as described in the Collective Bargaining Agreement. In order to receive services provided by a personal support worker, an individual, the designated common law employer or the common law employer proxy must provide written authorization and consent to the Department for the provision of workers' compensation insurance for the personal support worker.

(3) COMMUNITY TRANSPORTATION.

(a) A personal support worker may be reimbursed for providing community transportation related to services if the community transportation is prior authorized by a case manager and reflected in the ISP for an individual in accordance with OAR 411-435-0050. A personal support worker providing community transportation must have a valid license to drive, a good driving record, and proof of insurance for the vehicle used to transport the individual, as well as

any other license or certificate that may be required under state and local law depending on the nature and scope of the transportation.

(b) Community transportation services exclude medical transportation. Medical transportation is provided through Medical Assistance Programs (MAP).

(c) The Department is not responsible for vehicle damage or personal injury sustained while using a personal motor vehicle for ISP-related transportation except as may be covered by workers' compensation.

(d) Reimbursement for transporting an individual to accomplish ADL, IADL, or a health-related task within the community in which the individual lives or an employment goal identified on an ISP is on a per-mile basis as outlined in the Collective Bargaining Agreement.

(4) TRAVEL BETWEEN WORKSITES. A personal support worker who travels directly between the home or service setting of one individual and the home or service setting of another individual is paid at the base pay rate, as defined in the Collective Bargaining Agreement, for the time spent traveling directly between the homes or service settings.

(a) Unless otherwise specified in statute or rule the amount of time a personal support worker may take to travel directly travel from one individual's home or service setting to another individual's home or service setting may not exceed one hour.

(b) The total time spent traveling directly between the homes or service settings of all individuals a personal support worker is authorized to deliver services to may not total more than ten percent of the total wages that the personal support worker claims during a pay period as described in the Collective Bargaining Agreement.

(c) When a personal support worker uses the personal support worker's own vehicle to travel directly between the homes or service settings of two individuals, the Department shall determine the time needed for a personal support worker to travel directly between the homes or service settings of the two individuals based on a time estimate published in a common, publicly-available, web-based mapping program.

(d) When a personal support worker uses public transportation to travel directly between the homes or service settings of two individuals, payment for travel time is based on the public transportation providers' scheduled pick-up and drop-off times for the stops nearest the individuals' homes or service settings.

(e) When a personal support worker uses non-motorized transportation to travel directly between the homes or service settings of two individuals, payment for travel time shall be based on a time estimate published in a common, publicly-available web-based mapping program.

(5) Claims for travel time exceeding the Department's time estimates for the travel time require a written explanation from the personal support worker. Time claimed in excess of the Department's time estimate may not be paid.

(6) Under no circumstances may a personal support worker be paid for time spent in transit to or from the personal support worker's own residence.

(7) Personal support workers receive mileage reimbursement only as set forth in section (3) of this rule.

(8) GLOVES AND MASKS. Once all public and private resources have been exhausted, an emergency supply of protective gloves and masks must be made available to a personal support worker for the safety of the personal support worker in response to documented changing or newly identified individual need as outlined in the Collective Bargaining Agreement.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-619, 427.007

411-375-0055 Standards for Common Law Employers for Personal Support Workers

(Adopted 06/29/2016)

(1) COMMON LAW EMPLOYER. A common law employer is required when a personal support worker is selected by an individual to deliver supports. Neither the Department, certified and endorsed or licensed provider agencies, nor case management entities may act as the common law employer for a personal support worker.

(2) The relationship between a personal support worker and an individual, or the designated common law employer of the individual, is an employee and employer relationship.

(3) The individual or their legal or designated representative has the right to choose any personal support worker enrolled as a provider as described in OAR 411-375-0020 who meets the specific program qualifications.

(4) SERVICE AGREEMENT. Common law employers must assure the implementation of a Service Agreement.

(5) BENEFITS. Common law employers do not qualify for any benefits including, but not limited to, financial compensation.

(6) COMMON LAW EMPLOYER REQUIREMENTS.

(a) Common law employers must be:

(A) The individual.

(B) A person who is designated by the individual or their legal or designated representative to act as the common law employer on behalf of the individual to meet all of the employer responsibilities described in subsection (b) of this section. The legal or designated representative of an individual may be the employer. As of October 1, 2016, no one may be a designated common law employer or proxy who does not sign a Department-approved form which affirms the designated common law employer is able to fulfill the responsibilities, or responsibilities delegated to them, as outlined in subsection (b) of this section. The designated common law employer must not have:

(i) A history of substantiated abuse of an adult as described in OAR 411-045-0250 to 411-045-0370;

(ii) A history of founded abuse of a child as described in ORS 419B.005;

(iii) A conviction of any crimes found in OAR 407-007-0280(1); or

(iv) An indictment or conviction of fraud pursuant to federal law under 42 CFR 455.23.

(C) Not currently employed as a provider in any capacity for the individual receiving services.

(D) Meet federal and state requirements to enter an employment relationship.

(b) Common law employers have the following responsibilities:

(A) Locating, screening, and hiring a qualified personal support worker.

(B) Assisting in developing the Service Agreement with the case management entity as needed.

(C) Ensuring that services are delivered in accordance with the Service Agreement.

(D) Supervising and training the personal support worker.

(E) Scheduling work, leave, and coverage.

(F) Tracking the hours worked and verifying the authorized hours completed by the personal support worker.

(G) Recognizing, discussing, and attempting to correct, with the personal support worker any performance deficiencies and provide appropriate and progressive disciplinary action as needed.

(H) Notifying the case management entity of any suspected fraud or abuse by the personal support worker.

(I) Discharging an unsatisfactory personal support worker.

(c) The Department or case management entity may be required to intervene as described in section (7) of this rule when a common law employer, designated common law employer, or common law employer proxy has demonstrated an inability to meet one or more of the employer responsibilities described in subsection (b) of this section. Indicators that an employer may not be meeting one or more of the responsibilities include, but are not limited to:

(A) Provider complaints to the case management entity or Department;

(B) Scheduling providers for more time than authorized in the Service Agreement;

(C) Scheduling multiple providers for the same time period without authorization;

(D) Approving time worked without verifying that services were delivered as described in the Service Agreement;

(E) Verifying time not actually worked by a provider;

(F) Refusal to verify time worked by a provider for services that were delivered as described in the Service Agreement;

(G) Complaints to Medicaid fraud involving the employer; or

(H) Documented observation by the case management entity or Department that services are not being delivered as identified in a Service Agreement.

(d) In the event an individual is unable or unwilling to perform the duties of a common law employer and has not already designated a

common law employer, the individual or their legal or designated representative must either:

(A) Designate a common law employer proxy (proxy) as defined in OAR 411-375-0010 that meets the requirements of a common law employer in subsection (a)(B) of this section.

(i) A proxy may not be delegated all of the responsibilities of the common law employer.

(ii) The proxy may not perform any common law employer tasks not delegated to the proxy on a Department approved form.

(B) Designate a common law employer as outlined in subsection (a)(B) of this section.

(e) A designated common law employer must be able to fulfill all of the duties as outlined in subsection (b) of this section and may not utilize a designated employer proxy.

(f) If an individual is unable to fulfill the responsibilities of a common law employer and is unable to designate a proxy or other common law employer who meets the requirements outlined in subsection (a)(B) of this section, the individual may only select services from providers who are not personal support workers.

(7) INTERVENTION.

(a) For the purposes of this rule, “intervention” means the action the Department or the case management entity requires when a common law employer fails to meet the responsibilities as described in section (6)(b) of this rule.

(b) Interventions are:

(A) A review of the employer responsibilities described in section (6)(b) of this rule;

(B) Training related to employer responsibilities or referral to a Department approved resource to provide training;

(C) Corrective action taken as a result of a personal support worker filing a complaint with the Department or the case management entity; or

(D) Recommending alternative designation of common law employer responsibilities, such as a new designated common law employer or proxy.

(c) Any intervention initiated by the Department or the case management entity against a common law employer designated prior to October 1, 2016 must include the employer indicating acceptance of the common law employer responsibilities as outlined in section (6)(b) of this rule using the Department approved form.

(8) REMOVAL OF COMMON LAW EMPLOYERS.

(a) The individual or their legal or designated representative may remove a designated common law employer or proxy at any time, for any reason. Such an action by the individual or their legal or designated representative is not subject to sections (8)(b) through (9) of this rule.

(b) Prior to the removal of any common law employer by the Department or case management entity there must be at least one intervention, as described in section (7) of this rule unless:

(A) There is an imminent danger to the health and safety of the individual receiving services including:

(i) Pending charges against or conviction of the designated common law employer or proxy for any crimes found in OAR 407-007-0280(1).

(ii) An open protective services case for abuse allegations as defined in OAR 407-045-0260 against the designated common law employer or proxy.

(iii) Finding of substantiated abuse of an adult as described in OAR 411-040-0250 to 411-045-0370.

(iv) Finding of abuse of a child as described in ORS 419B.005.

(B) There is a credible allegation, indictment, or conviction of fraud pursuant to federal law under 42 CFR 455.23.

(c) The Department or case management entity shall remove any common law employer or proxy for any violation of section (6)(a)(B)(i) to (a)(B)(iv) or section (8)(b) of this rule.

(d) Any common law employer or proxy may be removed by the case management entity or Department for failure to meet the responsibilities of a common law employer as referenced in section (6)(b) after a documented intervention as outlined in section (7) of this rule.

(e) Common law employers or proxies who are removed may not act in any capacity as a common law employer or proxy for any individual receiving Department funded services effective:

(A) 30 days from the date of removal; or

(B) Immediately if removed for reasons listed under section (6)(b) of this rule.

(f) If a designated common law employer or proxy is removed the individual, or their legal or designated representative may select another designated common law employer or proxy. If a designated common law employer or proxy is not selected and the individual is unable or unwilling to serve as their own common law employer, the individual may only select providers who are not personal support workers.

(9) NOTIFICATION OF COMMON LAW EMPLOYER REMOVAL. The Department or case management entity shall notify the designated common law employer and the individual and their legal or designated representative (as applicable) of the removal of the common law employer.

(10) REQUEST FOR REINSTATEMENT OF COMMON LAW EMPLOYER STATUS.

(a) An individual, designated common law employer, or proxy is eligible to request reinstatement of their previous common law employer status if:

(A) The common law employer was the individual; or

(B) The designated common law employer or proxy no longer meets the criteria in section (8)(b) of this rule or is removed under section (8)(c) of this rule and the individual or their legal or designated representative agrees to the reinstatement.

(b) Requests for reinstatement:

(A) Must be submitted to the case management entity.

(B) Must include evidence of improvement in the areas for which they were removed. Evidence may include, but is not limited to:

(i) Improvements in health and cognitive functioning; or

(ii) Participation in a Department or case management entity approved training plan.

(C) May be approved by the case management entity when there is evidence of improvement in the ability to perform the responsibilities of being a common law employer and the individual agrees with the reinstatement.

(D) No more than one request for reinstatement may be submitted in a six month period unless approved by the case management entity.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0060 Overpayments

(6/26/2016 Renumbered to 411-375-0045)

411-375-0070 Provider Enrollment Inactivation and Termination

(Amended 06/29/2016)

(1) An independent provider may not be paid for work performed while their provider number is inactivated. A provider number for an independent provider may be inactivated by the Department until the independent provider takes action to reinstate their provider enrollment when:

- (a) The independent provider has not provided any paid services to an individual within the previous 12 months;
- (b) The independent provider informs the case management entity that the independent provider is no longer providing services in Oregon;
- (c) For a personal support worker, the personal support worker fails to participate in a required orientation for personal support workers as described in the Collective Bargaining Agreement;
- (d) The background check for an independent provider results in a closed case pursuant to OAR 407-007-0325;
- (e) More than two years have passed since the date on the most recent background check final fitness determination for an independent provider;
- (f) More than two years have passed since the signature date on the most recent Provider Enrollment Application and Agreement for an independent provider;
- (g) The independent provider fails to participate in training required by the Department; or
- (h) The independent provider does not request a hearing within 10 business days of a notice of proposed termination.

(2) An independent provider may not be paid for work performed while their provider number is inactivated during an investigation when:

(a) The independent provider, even if not providing any paid services to an individual, is being investigated for alleged violation of protective services and abuse rules by a case management entity for suspected abuse that poses imminent danger to current or future individuals;

(b) The independent provider, even if not providing any paid services to an individual, is being investigated by law enforcement for any of the crimes listed in OAR 407-007-0275; or

(c) The independent provider has a credible allegation of fraud pursuant to federal law under 42 CFR 455.23.

(3) An independent provider may not be paid for work performed while their provider number is terminated. A provider number for a independent provider may be terminated by the Department when:

(a) The independent provider violates the requirement to maintain a drug-free work place by:

(A) Being intoxicated by alcohol, inhalants, prescription drugs, or other drugs, including over-the-counter medications, while responsible for the care of an individual, while in the home of the individual, or while transporting the individual; or

(B) Manufacturing, possessing, selling, offering to sell, trading, or using illegal drugs while providing authorized services to an individual or while in the home of the individual.

(b) The independent provider has an unacceptable background check and the background check results in a closed case pursuant to OAR 407-007-0325;

(c) The independent provider demonstrates a lack of skills, knowledge, or ability to adequately or safely provide services as defined in these rules;

(d) The independent provider has a violation of the protective service and abuse rules as defined in these rules;

(e) Notwithstanding abuse as defined in OAR 407-045-0260, OAR 411-020-0002, OAR 943-045-0260, or child abuse and neglect as defined in OAR-413-015-0115, the independent provider fails to safely and adequately provide authorized services;

(f) The independent provider commits fiscal improprieties including, but not limited to, billing excessive or fraudulent charges or has a conviction for fraud pursuant to federal law under 42 CFR 455.23;

(g) The independent provider fails to provide services as required as defined in these rules and as described in the Service Agreement;

(h) The independent provider lacks the ability or willingness to maintain individual confidentiality;

(i) The independent provider engages in repeated unacceptable conduct at work, such as:

(A) Delay in arriving to work or absences from work not scheduled in advance with the individual or the representative of the individual that are either unsatisfactory to the individual or the representative of the individual or that neglect the service needs of the individual; or

(B) Inviting unwelcome guests or pets into the home or community with the individual resulting in the dissatisfaction of the individual or the representative of the individual or inattention to the service needs of the individual.

(j) The independent provider has been excluded or debarred by the Office of the Inspector General;

(k) The independent provider fails to perform the applicable duties as a mandatory reporter; or

(l) The independent provider fails to provide a tax identification number or social security number that matches the independent

provider's legal name as verified by the Internal Revenue Service or Social Security Administration.

(4) NOTIFICATION OF PROPOSED CHANGE IN PROVIDER NUMBER STATUS.

(a) The Department must issue a written notice of the proposed inactivation of a provider number to the independent provider when the inactivation is based on section (1)(g) or section (2) of this rule.

(b) The Department must issue a written notice of the proposed termination of a provider number to the independent provider.

(c) The Department-issued written notice of change in provider number status to the independent provider must include:

(A) An explanation of the reason for terminating or inactivating the provider number.

(B) The alleged violation as listed in sections (1) or (2) of this rule.

(C) The hearing rights, if any, of the independent provider as described in OAR 411-375-0080, including the right to legal representation, if applicable, and where to file a request for hearing.

(D) The effective date of the termination or inactivation.

(d) For terminations based on violation of the abuse and protective services rules, the written notice of termination may only contain the information allowed by law. In accordance with ORS 430.753, 430.763, and OAR 411-020-0030, the name of a complainant, witness, or alleged victim, and protected health information may not be disclosed.

(5) RETENTION OF PROVIDER NUMBER PENDING HEARING OUTCOME. The provider number of an independent provider may not be inactivated during the first 10 business days after a notice of proposed termination to provide the opportunity for the independent provider to file a

request for hearing. The independent provider must file a request for hearing within 10 business days from the date of the notice of proposed termination if the independent provider wishes to continue to work during the hearing process as described in OAR 411-375-0080. If the independent provider files a written request for a hearing prior to the deadline, the provider number of the independent provider may not be inactivated or terminated until the hearing process is concluded.

(a) EXCLUSIONS. A independent provider may be terminated immediately by the Department and the independent provider may not continue to work during the hearing process as described in OAR 411-375-0080 when:

(A) Termination is based on a background check. The independent provider has the right to a hearing in accordance with OAR 407-007-0200 to 407-007-0370;

(B) Termination is based on being excluded or debarred by the Office of the Inspector General;

(C) Termination is based on a conviction for fraud pursuant to federal law under 42 CFR 455.23; or

(D) Termination is based on an alleged violation listed in section (3) of this rule and the alleged violation presents imminent danger to current or future individuals.

(b) The independent provider must file a request for hearing within 30 days from the date of the notice of termination as described in OAR 411-375-0080.

(6) TERMINATION IF NO HEARING REQUEST FILED.

(a) The decision of the Department becomes final if an independent provider does not request a hearing within 30 days from the date of the notice of termination.

(b) The Department will issue a Final Order by Default to the independent provider in accordance with OAR 137-003-0670. The provider enrollment for a independent provider is terminated once the

time period for the independent provider to request a hearing has expired.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007

411-375-0080 Hearing Rights

(Amended 06/29/2016)

(1) EXCLUSIONS. The following are excluded from the hearings process described in this rule:

(a) Terminations based on a background check. The independent provider has the right to a hearing in accordance with OAR 407-007-0200 to 407-007-0370.

(b) Termination based on being excluded or debarred by the Office of the Inspector General.

(c) Termination based on a conviction for fraud pursuant to federal law under 42 CFR 455.23.

(d) Independent providers that have been inactivated under OAR 411-375-0070(1) or (2).

(e) Independent providers that are denied a provider enrollment number at the time of initial application.

(2) HEARING REQUESTS.

(a) A independent provider may file a request for a hearing with the Department if the independent provider disputes the decision to terminate the provider number of the independent provider except when excluded under section (1) of this rule. If an independent provider decides to file a request for hearing, the independent provider must specify in the request, the issues or decisions being disputed and the reason for the request.

(b) The request for a hearing must be filed in writing on the Department approved form with the Department within 30 days from

the effective date of the termination included on the termination notice.

(3) **INFORMAL CONFERENCE.** The Department offers an informal conference, as described in OAR 461-025-0325, to an independent provider within five business days from the receipt of a request for hearing.

(a) The independent provider has 10 business days to respond to the offer for an informal conference with the Department.

(b) If the independent provider accepts the offer of an informal conference, the informal conference must be scheduled with the independent provider and, if requested, a legal representative. The informal conference must involve the independent provider and the Department to review the facts, and explain the decision to terminate the provider enrollment. The informal conference may be held by telephone. At the discretion of the Department representative, the Department representative may grant an additional informal conference to facilitate the hearing process.

(c) Participation in an informal conference by the independent provider is not required.

(4) The referral of a hearing request by the Department to the Office of Administrative Hearings is subject to OAR 137-003-0515.

(5) **BURDEN OF PROOF.** The Department has the burden of proving the decision to terminate the provider enrollment of an independent provider by a preponderance of the evidence. Evidence submitted for a hearing is governed by OAR 137-003-0610.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 410.600, 410.606-410.619, 427.007