Secretary of State
Certificate and Order for Filing

TEMPORARY ADMINISTRATIVE RULES

A Statement of Need and Justification accompanies this form..

I certify that the attached copies* are true, full and correct copies of the TEMPORARY Rule(s) adopted on [upon filing] by the
Date prior to or same as filing date

Department of Human Services, Aging and People with Disabilities 411

Agency and Division | Administrative Rules Chapter Number

Christina Hartman | 500 Summer Street NE, E-10, Salem, OR 97301-1074 | (503) 945-6398

Rules Coordinator | Address | Telephone

to become effective [July 1, 2013] through [December 28, 2013].
Date upon filing or later | A maximum of 180 days including the effective date.

RULE CAPTION

Medicaid Services - Home and Community-Based Waivered and State Plan Services

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

RULEMAKING ACTION

List each rule number separately, 000-000-0000.
Secure approval of new rule numbers (Adopted rules) with the Administrative Rules Unit prior to filing

ADOPT:

AMEND:

411-001-0510, 411-015-0005, 411-015-0008, 411-015-0015, 411-015-0100, 411-030-0070, 411-030-0100, 411-040-0000, 411-045-0010, 411-045-0050, 411-048-0150, 411-048-0160, 411-048-0170, 411-065-0000, 411-070-0033

SUSPEND:

Stat. Auth.: ORS 410.070

Other Auth.:

Stats. Implemented: ORS 410.070

RULE SUMMARY

The Department of Human Services (Department) is immediately amending the rules for Aging and People with Disabilities (APD) in OAR chapter 411 to be in compliance with new Medicaid authority to provide both home and community-based waivered and state plan services.

Signed Michael McCormick, Deputy Director, Aging and People with Disabilities 6/30/2013
Signature | Date

Secretary of State

STATEMENT OF NEED AND JUSTIFICATION

A Certificate and Order for Filing Temporary Administrative Rules accompanies this form.

Department of Human Services, Aging and People with Disabilities 411

Agency and Division | Administrative Rules Chapter Number

In the Matter of: The temporary amendment of OAR 411-001-0510, 411-015-0005, 411-015-0008, 411-015-0015, 411-015-0100, 411-030-0070, 411-030-0100, 411-040-0000, 411-045-0010, 411-045-0050, 411-048-0150, 411-048-0160, 411-048-0170, 411-065-0000, and 411-070-0033 relating to Aging and People with Disabilities.

Rule Caption: (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)
Medicaid Services - Home and Community-Based Waivered and State Plan Services

Statutory Authority: ORS 410.070

Other Authority:

Stats. Implemented: ORS 410.070

Need for the Temporary Rule(s):
The Department's rules for APD in OAR chapter 411 need to be immediately amended to be in compliance with new Medicaid authority to provide both home and community-based waivered and state plan services. The rules in OAR chapter 411 are being immediately amended to include references to both home and community-based waivered and state plan services.

Documents Relied Upon, and where they are available:
Aging and People with Disabilities 1915(k) State Plan
Available upon request by emailing the Administrative Rule Coordinator (christina.hartman@state.or.us) or calling 503-945-6398

Justification of Temporary Rule(s):
Failure to act promptly and immediately amend the rules for APD in OAR chapter 411 will result in serious prejudice to individuals receiving Medicaid services and the Department.

Failure to immediately amend the rules for APD in OAR chapter 411 will prevent the Department from using Medicaid funding to provide both home and community-based waivered and state plan services. This will lead to significant budgetary problems for the state and Medicaid service recipients will have less access to services.

The APD rules in OAR chapter 411 need to be amended promptly to include references to both home and community-based waivered and state plan services to comply with new Medicaid authority to provide both home and community-based waivered and state plan services.

Signed Michael McCormick, Deputy Director, Aging and People with Disabilities 6/30/2013

Signature Date

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

CHAPTER 411
DIVISION 1

CONTESTED CASE HEARINGS

411-001-0510 Lay Representation in Contested Case Hearings
(Temporary Effective 7/1/2013 - 12/28/2013)

(1) Subject to the approval of the Attorney General, an officer or employee of the Department of Human Services (Department) is authorized to appear on behalf of the Department in the following types of hearings conducted by the Office of Administrative Hearings:

(a) Eligibility for services available through a waiver or state plan administered by the Department's Aging and People with Disabilities (APD) or Developmental Disabilities (DD), including but not limited to the level or amount of benefits, and effective date;

(b) Eligibility for medical benefits, the level and amount of benefits, and effective date;

(c) Overpayments related to waivered or state plan service benefits or medical benefits;

(d) Suspension, reduction, or denial of medical assistance services, prior authorizations, or medical management decisions; and

(e) Consumer-employed provider matters, including but not limited to provider enrollment or denial of enrollment, overpayment determinations, audits, and sanctions.

(2) A Department officer or employee acting as the Department's representative may not make legal argument on behalf of the Department.

(a) "Legal argument" includes arguments on:

(A) The jurisdiction of the Department to hear the contested case;

(B) The constitutionality of a statute or rule or the application of a constitutional requirement to the Department; and

(C) The application of court precedent to the facts of the particular contested case proceeding.

(b) "Legal argument" does not include presentation of motions, evidence, examination and cross-examination of witnesses, or presentation of factual arguments or arguments on:

(A) The application of the statutes or rules to the facts in the contested case;

(B) Comparison of prior actions of the Department in handling similar situations;

(C) The literal meaning of the statutes or rules directly applicable to the issues in the contested case;

(D) The admissibility of evidence; and

(E) The correctness of procedures being followed in the contested case hearing.

(3) When an officer or employee appears on behalf of the Department, the administrative law judge shall advise the Department's representative of the manner in which objections may be made and matters preserved for appeal. Such advice is of a procedural nature and does not change applicable law on waiver or the duty to make timely objection.

(4) If the administrative law judge determines that statements or objections made by the Department representative appearing under section (1) of this rule involve legal argument as defined in this rule, the administrative law judge shall provide reasonable opportunity for the Department representative to consult the Attorney General and permit the Attorney

General to present argument at the hearing or to file written legal argument within a reasonable time after conclusion of the hearing.

(5) The Department is subject to the Code of Conduct for Non-Attorney Representatives at Administrative Hearings, which is maintained by the Oregon Department of Justice and available on its website at http://www.doj.state.or.us. A Department representative appearing under section (1) of this rule must read and be familiar with the Code of Conduct for Non-Attorney Representatives at Administrative Hearings.

(6) When a Department officer or employee represents the Department in a contested case hearing, requests for admission and written interrogatories are not permitted.

Stat. Auth: ORS 409.050
Stats Implemented: ORS 183.452, 409.010

CHAPTER 411
DIVISION 15

LONG-TERM CARE SERVICE PRIORITIES FOR INDIVIDUALS SERVED

411-015-0005 Definitions
(Temporary Effective 7/1/2013 - 12/28/2013)

(~~2~~1) "~~Seniors~~ Aging and People with Disabilities Division (~~SPD~~APD)" means the part of the Department of Human Services responsible for the administration of programs to ~~seniors~~ older adults and ~~people~~ individuals with physical disabilities. Many of the services are provided to individuals through local Area Agency on Aging (AAA) and disability (AAAD) offices. The term "Aging and People with Disabilities Division" is synonymous with "Seniors and People with Disabilities Division" and "Department".

(~~1~~2) "All ~~p~~Phases" means each part of an activity.

(~~2~~3) "Alternative Service Resources" means other possible resources for the provision of services to meet the individual's needs. This includes, but is not limited to, natural supports (relatives, friends, significant others, roommates, neighbors or the community), Risk Intervention services, Older

Americans Act programs, or other community supports. Alternative Service Resources are not paid by Medicaid.

(~~3~~4) "Architectural Modifications" means any service leading to the alteration of the structure of a dwelling to meet the specific service need of the eligible individual.

(~~4~~5) "Area Agency on Aging (AAA)" means the Department ~~of Human Services (DHS)~~ designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to seniors and possibly individuals with disabilities in a planning and service area. For purposes of these rules, the term Area Agency on Aging (AAA) is inclusive of both Type A and Type B Area Agencies on Aging as defined in ORS 410.040 through 410.300.

(~~5~~6) "Assistance Types" needed for activities of daily living and instrumental activities of daily living include, but are not limited to the following terms:

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

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

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

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

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

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

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

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

(~~6~~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 (ADL). This definition includes the use of service animals, general household items or furniture to assist the individual.

(~~7~~8) "Behavioral Care ~~p~~Plan" means a documented set of procedures, reviewed by the Department or AAA representative, which describes interventions for use by the provider to prevent, mitigate or respond to behavioral symptoms that negatively impact the health and safety of an individual or others in the home or ~~care~~ community-based services setting. The preferences of the individual should be included in developing the plan.

(~~8~~9) "Business ~~d~~Days and ~~h~~Hours" means Monday through Friday and excludes Saturdays, Sundays and state or federal holidays. Hours are from 8:00 AM to 5:00 PM.

(10) "Case Manager" means a~~n~~ ~~SPD/~~ Department or AAA employee who assesses the service needs of an applicant or eligible individual, determines eligibility and offers service choices to eligible individuals. The Case Manager authorizes and implements the service plan and monitors the services delivered.

(11) "Client Assessment and Planning System (CA/PS)" is a single entry data system used for completing a comprehensive and holistic assessment, surveying the individual's physical, mental, and social functioning, and identifying risk factors, individual choices and preferences, and the status of service needs. The CA/PS documents the level of need and calculates the individual's service priority level in accordance with OAR chapter 411, division 015 rules, calculates the service payment rates, and accommodates ~~client~~ individual participation in service planning.

(12) "Cost ~~e~~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 the available services on the

Department's published ~~SPD~~ rate schedule, the utilization of assistive devices or architectural modifications and alternative service resources. Less costly alternatives may include resources not paid for by the Department.

(13) "Department" means the Department of Human Services~~,~~ (DHS)~~,~~. The term "Department" is synonymous with "Seniors and People with Disabilities Division (SPD)" and "Aging and People with Disabilities Division".

(14) "Extraordinary ~~c~~Circumstances" means:

(a) The individual being assessed is working full time during business hours; or

(b) A family member, whose presence is requested by the individual being assessed, is traveling from outside the area and is available for only a limited period of time which does not include business days and hours.

(15) "Functional Impairment" means an individual's pattern of mental and physical limitations that restricts the individual's ability to perform activities of daily living and instrumental activities of daily living without the assistance of another person.

~~(16) "Home and Community Based Waivered Services" means services approved for Oregon by the Centers for Medicare and Medicaid Services for seniors and people with physical disabilities in accordance with Sections 1915 (c) and 1115 of Title XIX of the Social Security Act.~~

(~~17~~16) "Independent" means the individual does not meet the definition of "Assist" or "Full Assist" when assessing an Activity of Daily Living as defined in OAR 411-015-0006 or, when assessing an Instrumental Activity of Daily Living as defined in OAR 411-015-0007.

(~~18~~17) "Individual" means the person applying or eligible for services. "Client" is synonymous with individual.

(~~19~~18) "Mental or Emotional Disorder" means a schizophrenic, mood, paranoid, panic or other anxiety disorder; somatoform, personality,

dissociative, factitious, eating, sleeping, impulse control or adjustment disorder or other psychotic disorder, as defined in the Diagnostic and Statistical Manual, published in 1994 by the American Psychiatric Association.

(~~20~~19) "Natural Supports" or "Natural Support ~~s~~System" means the resources available to an individual from their relatives, friends, significant others, neighbors, roommates and the community. Services provided by natural supports are resources not paid for by the Department. Exceptions are permitted in the Independent Choices Program defined in OAR chapter 411, division 036, at service re-assessments only.

(~~22~~20) "Service Priority Level (SPL)" means the order in which Department and AAA staff identifies individuals eligible for a Nursing Facility, ~~or Home and Community Based Waivered Services programs, Spousal Pay Program and~~ Oregon Project Independence, or home and community-based waivered or state plan services. A lower service priority level number indicates greater or more severe functional impairment. The number is synonymous with the service priority level.

(~~9~~21) "~~Care~~ Service ~~s~~Setting" means a Medicaid contracted facility at which the Medicaid eligible individual resides and receives services. ~~Care~~ Service settings are adult foster homes, residential care facilities, assisted living facilities, specialized living contracted residences and nursing facilities.

(~~23~~22) "Substance ~~a~~Abuse ~~r~~Related ~~d~~Disorders" means disorders related to the taking of a drug or toxin of abuse (including alcohol) and the side effects of medication. These disorders include substance dependency and substance abuse, alcohol dependency and alcohol abuse, substance induced disorders and alcohol induced disorders as defined in the Diagnostic and Statistical Manual, published in 1994 by the American Psychiatric Association. Substance abuse related disorders are not considered physical disabilities. Dementia or other long term physical or health impairments resulting from substance abuse may be considered physical disabilities.

(~~24~~23) "Without ~~s~~Supports" means lacking the assistance of another person, a care setting and its staff or an alternative service resource defined in OAR 411-015-0005.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.060, 410.070, ~~&~~ and 414.065

411-015-0008 Assessments
(Temporary Effective 7/1/2013 - 12/28/2013)

(1) ~~Assessment~~ASSESSMENT. The assessment process will identify the individual's ability to perform activities of daily living, instrumental activities of daily living (self-management tasks), and determine the individual's ability to address health and safety concerns and his or her preferences to meet needs. The case manager will conduct this assessment in accordance with standards of practices established by the Department.

(a) The case manager must assess the individual's abilities regardless of architectural modifications, assistive devices or services provided by care facilities, alternative service resources or other community providers.

(b) The time frame reference for evaluation is how the individual functioned during the thirty days prior to the assessment date, with consideration of how the person is likely to function in the thirty days following the assessment date:

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

(B) The time frame for assessing the Cognition/Behavior Activity of Daily Living may be extended as noted in OAR 411-015-0006.

(c) The assessment will be conducted by a case manager or other qualified Department or Area Agency on Aging representative no less than annually, with a standardized assessment tool approved by ~~Seniors and People with Disabilities~~the Department.

(d) The initial assessment will be conducted face to face in the individual's home or care setting. Annual re-assessments will be conducted face to face in the individual's home or care setting unless

there is a compelling reason to meet elsewhere and the individual requests an alternative location. Case Managers are required to visit the individual's home or care setting to complete the re-assessment and identify service plan needs, as well as safety and risk concerns.

(e) Effective July 1, 2006, individuals will be sent a notice of the need for re-assessment a minimum of fourteen (14) days in advance. Re-assessments based on a change in the individual's condition or needs are exempt from the 14-day advance notice requirement.

(f) The individual being assessed may request the presence of natural supports at any assessment.

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

(2) ~~Service Plan~~SERVICE PLAN:

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

(b) The case manager has responsibility for determining eligibility for specific services, presenting alternatives to the individual, identifying risks and assessing the cost effectiveness of the plan. The case manager will monitor the plan and make adjustments as needed based on the service needs of the individual.

(c) The eligible individual, or their representative, has the responsibility to choose and assist in developing less costly service alternatives.

(d) The Service Plan payment will be considered full payment for the services rendered under Title XIX. Under no circumstances may any

provider demand or receive additional payment for Title XIX-covered services from the eligible individual or any other source.

(3) The applicant or their representative has the responsibility to participate in and provide information necessary to complete assessments and re-assessments within the time frame requested by the Department. Failure to participate in or provide requested assessment or re-assessment information within the application time frame will result in a denial of service eligibility for a Nursing Facility~~, Spousal Pay, Title XIX Home and Community Based waivered and Independent Choices Program services~~ or home and community-based waivered or state plan services. The Department may allow additional time if there are circumstances beyond the control of the individual or the individual's representative which prevent timely participation or timely submission of information.

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

411-015-0015 Current Limitations
(Temporary Effective 7/1/2013 - 12/28/2013)

The Department has the authority to establish by Administrative Rule service eligibility within which to manage its limited resources. The Department is currently able to serve:

(1) Individuals determined eligible for OSIPM who are assessed as meeting at least one of the service priority levels (1) through (13) as defined in OAR 411-015-0010.

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

(3) Individuals needing Risk Intervention Services in areas designated to provide such services. Individuals with the lowest service priority level number under OAR 411-015-0010 will be served first.

(4) The following persons:

(a) Individuals sixty-five years of age or older determined eligible for Developmental Disability services or having a primary diagnosis of a mental or emotional disorder are eligible for nursing facility ~~and~~ or home and community-based waivered or state plan services if they meet sections (1), (2), or (3) of this rule and are not in need of specialized mental health treatment services or other specialized Department residential program intervention as identified through the PASRR process defined in OAR 411-070-0043 or mental health assessment process.

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

(c) Individuals under sixty-five years of age determined to be eligible for developmental disabilities services are not eligible for ~~Title XIX Home and Community Based Waivered Services paid for under the Department's 1915C Waiver for seniors and people with physical disabilities~~home and community-based waivered or state plan services administered by the Department's Aging and People with Disabilities Division. Eligibility for home and community-based waivered or state plan services for individuals with intellectual or developmental disabilities is determined by the Department's Office of Developmental Disabilities or designee.

(d) Individuals under sixty-five years of age who have a diagnosis of mental or emotional disorder or substance abuse related disorder are not eligible for ~~Title XIX Home and Community Based Waivered Services paid for under the Department's 1915C Waiver for seniors and people with physical disabilities~~home and community-based waivered or state plan services unless:

(A) They have a medical non-psychiatric diagnosis or physical disability; and

(B) Their need for services is based on their medical non-psychiatric diagnosis or physical disability; and

(C) They provide supporting documentation demonstrating that their need for services is based on the medical, non-psychiatric diagnosis or physical disability. The Department will authorize documentation sources through approved and published policy transmittals.

(5) ~~Title XIX Home and Community Based Waivered Services paid for under the Department's 1915 (c) Waiver~~Home and community-based waivered or state plan services are not intended to replace the resources available to ~~a client~~an individual from their natural support system. Natural supports are voluntary in nature and must not be assumed. Natural supports must have the skills and abilities to perform the services needed by an individual. Individuals whose service needs are met by their alternative service resources are not eligible for ~~Title XIX Home and Community Based Waivered Services~~home and community-based waivered or state plan services. Services may be authorized only when the alternative service resources are unavailable, insufficient or inadequate to meet the needs of the individual.

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

Stat. Auth.: ORS 410.070 & 411.070
Stats. Implemented: ORS 410.070

411-015-0100 Eligibility for Nursing Facility or Home and Community-Based Waivered or State Plan Services
(Temporary Effective 7/1/2013 - 12/28/2013)

(1) To be eligible for nursing facility services~~,~~ or home and ~~C~~community-based waivered or state plan services ~~for aged and physically disabled, Independent Choices, Spousal Pay, or the Program of All-inclusive Care for the Elderly (PACE)~~, a person must:

(a) Be age 18 or older; and

(b) Be eligible for OSIPM; and

(c) Meet the functional impairment level within the service priority levels currently served by ~~Seniors and People with Disabilities~~the

Department as outlined in OAR 411-015-0010 and the requirements in OAR 411-015-0015; or

(d) To be eligible to have services paid through the State Spousal Pay Program, the person must meet requirements as listed above in subsection (a), (b), & (c), and in addition, the requirements in OAR 411-030-0080.

(2) Individuals who are age 17 or younger and reside in a nursing facility are eligible for nursing facility services only. They are not eligible to receive home and ~~C~~community-based waivered or state plan services~~, Spousal Pay or Independent Choices program services~~.

Stat. Auth.: ORS 410.070
Stats. Implemented: ORS 410.060, 410.070, ~~&~~ and 414.065

CHAPTER 411
DIVISION 30

IN-HOME SERVICES

411-030-0070 Maximum Hours of Service
(Temporary Effective 7/1/2013 - 12/28/2013)

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

(a) "Minimal Assistance" means the individual is able to perform the majority of an activity, but requires some assistance from another person.

(b) "Substantial Assistance" means the individual can perform only a small portion of the tasks that comprise the activity without assistance from another person.

(c) "Full Assistance" means the individual needs assistance from another person through all phases of the 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 the individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

(A) Eating:

(i) Minimal assistance, 5 hours;

(ii) Substantial assistance, 20 hours;

(iii) Full assistance, 30 hours;

(B) Dressing/Grooming:

(i) Minimal assistance, 5 hours;

(ii) Substantial assistance, 15 hours;

(iii) Full assistance, 20 hours;

(C) Bathing and Personal Hygiene:

(i) Minimal assistance, 10 hours;

(ii) Substantial assistance, 15 hours;

(iii) Full assistance, 25 hours;

(D) Mobility:

(i) Minimal assistance, 10 hours;

(ii) Substantial assistance, 15 hours;

(iii) Full assistance, 25 hours;

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

(i) Minimal assistance, 10 hours;

(ii) Substantial assistance, 20 hours;

(iii) Full assistance, 25 hours;

(F) Cognition/Behavior:

(i) Minimal assistance, 5 hours;

(ii) Substantial assistance, 10 hours;

(iii) Full assistance, 20 hours.

(b) Service plan hours for ADL may only be authorized for an individual if the individual requires assistance (minimal, substantial, or full assist) from another person in that activity of daily living as determined by a service assessment applying the parameters in OAR 411-015-0006.

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

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

(3) MAXIMUM MONTHLY HOURS FOR IADL.

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

(A) Medication and Oxygen Management:

(i) Minimal assistance, 2 hours;

(ii) Substantial assistance, 4 hours;

(iii) Full assistance, 6 hours;

(B) Transportation or Escort Assistance:

(i) Minimal assistance, 2 hours;

(ii) Substantial assistance, 3 hours;

(iii) Full assistance, 5 hours;

(C) Meal Preparation:

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

(I) Breakfast, 4 hours;

(II) Lunch, 4 hours;

(III) Supper, 8 hours.

(ii) Minimal assistance effective January 1, 2012:

(I) Breakfast, 3 hours;

(II) Lunch, 3 hours;

(III) Supper, 7 hours.

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

(I) Breakfast, 8 hours;

(II) Lunch, 8 hours;

(III) Supper, 16 hours.

(iv) Substantial assistance effective January 1, 2012:

(I) Breakfast, 7 hours;

(II) Lunch, 7 hours;

(III) Supper, 14 hours.

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

(I) Breakfast, 12 hours;

(II) Lunch, 12 hours;

(III) Supper, 24 hours.

(vi) Full assistance effective January 1, 2012:

(I) Breakfast, 10 hours;

(II) Lunch, 10 hours;

(III) Supper, 21 hours.

(D) Shopping:

(i) Minimal assistance, 2 hours;

(ii) Substantial assistance, 4 hours;

(iii) Full assistance, 6 hours;

(E) Housecleaning:

(i) Minimal assistance:

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

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

(ii) Substantial assistance:

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

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

(iii) Full assistance:

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

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

(b) Rates shall be paid in accordance with the rate schedule. When a live-in employee is present, these hours may be paid at less than minimum wage according to the Fair Labor Standards Act. The Independent Choices Program cash benefit is based on the hours authorized for IADL tasks paid at the hourly rates. Participants of the Independent Choices Program may determine their own employee provider pay rates.

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

(d) Service plan hours for IADL tasks may only be authorized for an individual if the individual requires assistance (minimal, substantial, or full assist) from another person in that IADL task as determined by a service assessment applying the parameters in OAR 411-015-0007.

(4) TWENTY-FOUR HOUR AVAILABILITY.

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

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

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

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

(D) The individual requires full assist in at least three of the eight components of cognition/behavior (as defined in OAR 411-015-0006).

(b) The number of hours allowed per month shall have the following maximums. Hours authorized are based on the service needs of the individual. Case managers may authorize up to the amount of hours identified in these assistance levels (minimal, substantial, or full assist).

(A) Minimal assistance -- 60 hours. Minimal assistance hours may be authorized when an individual requires one of these assessed needs as defined in OAR 411-015-0006:

(i) Full assist in cognition; or

(ii) Full assist in toileting or bowel or bladder.

(B) Substantial assistance -- 110 hours. Substantial assistance hours may be authorized when an individual requires these assessed needs as defined in OAR 411-015-0006:

(i) Assist in transfer; and

(ii) Assist in ambulation; and

(iii) Full assist in cognition; or

(iv) Full assist in toileting or bowel or bladder.

(C) Full assistance -- 159 hours. Full assistance hours may be authorized when:

(i) The authorized provider cannot get at least five continuous hours of sleep in an eight hour period during a 24-hour work period; and

(ii) The eligible individual requires these assessed needs as defined in OAR 411-015-0006:

(I) Full assist in transfer; and

(II) Assist in mobility; or

(III) Full assist in toileting or bowel or bladder; or

(IV) Full assist in cognition.

(c) Service plans that include full-time live-in homecare workers or Independent Choices Program employee providers must include a minimum of 60 hours per month of 24-hour availability. When a live-in homecare worker or Independent Choices Program employee provider is employed less than full time, the hours must be pro-rated. Full-time means the live-in homecare worker is providing services to the ~~client~~consumer-employer seven days per week throughout a calendar month.

(d) Rates for 24-hour availability shall be in accordance with the rate schedule and paid at less than minimum wage according to the Fair Labor Standards Act and ORS 653.020.

(e) Twenty-four hour availability assumes the homecare worker is available to address the service needs of an individual as they arise throughout a 24-hour period. A homecare worker who engages in employment outside the eligible individual's home or building during the work periods the homecare worker is on duty, is not considered available to meet the service needs of the individual.

(5) Under no circumstances shall any provider receive payment from the Department for more than the total amount authorized by the Department on the service plan authorization form. All service payments must be prior-authorized by the Department/AAA.

(6) AUTHORIZED HOURS ARE SUBJECT TO THE AVAILABILITY OF FUNDS. Case managers must assess and utilize as appropriate, natural supports, cost-effective assistive devices, durable medical equipment, housing accommodations, and alternative service resources (as defined in OAR 411-015-0005) which could reduce the individual's reliance on paid in-home services hours.

(7) The Department may authorize paid in-home services only to the extent necessary to supplement potential or existing resources within the individual's natural supports system.

(8) Payment by the Department for home and community-based waivered ~~in-home~~ or state plan services shall only be made for those tasks described in this rule as ADL, IADL tasks, and 24-hour availability. Services must be authorized to meet the needs of the eligible individual and may not be provided to benefit the entire household.

(9) EXCEPTIONS TO MAXIMUM HOURS OF SERVICE.

(a) To meet an extraordinary ADL service need that has been documented, the hours authorized for ADL may exceed the full assistance hours (described in section (2) of this rule) as long as the total number of ADL hours in the service plan does not exceed 145 hours per month.

(b) Monthly service payments that exceed 145 ADL hours per month may be approved by the Department when the exceptional payment criteria identified in OAR 411-027-0020 and OAR 411-027-0050 is met.

(c) Monthly service plans that exceed 145 ADL, 76 IADL, and 159 24-hour availability hours per month for a live-in homecare worker or Independent Choices Program employee provider, or that exceed the equivalent monthly service payment for an hourly services plan, may be approved by the Department when the exceptional payment

criteria identified in OAR 411-027-0020 and OAR 411-027-0050 is met.

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

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

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

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

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

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

411-030-0100 Independent Choices Program
(Temporary Effective 7/1/2013 - 12/28/2013)

(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) ~~SPD shall~~ 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) ~~SPD shall~~The Department enters names on the waiting list according to the date submitted by the ~~SPD/~~Department or AAA office.

(c) As vacancies occur, eligible individuals on the waiting list shall be offered the ICP in order according to their place on the waiting list.

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

(3) INITIAL ELIGIBILITY REQUIREMENTS.

(a) To be eligible for the ICP an individual must:

(A) Meet all program requirements of the In-Home Services Program in these rules;

(B) Develop a service plan and budget to meet the needs identified in the 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 the 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 ~~criminal history~~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 the 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. Participants, or their representative, who have met the eligibility criteria in section (3)(b) of this rule, may also choose to use a fiscal intermediary. The participant is responsible for any fees or payment to the fiscal intermediary and may allocate the fees or payment from their discretionary funds or other non ICP funds.

(4) DISENROLLMENT CRITERIA. Participants may be disenrolled from the ICP voluntarily or involuntarily. Participants who are disenrolled from the ICP may not reapply for six months. After the six month disenrollment period, an individual may re-enroll and must meet all ICP eligibility requirements. If the ICP enrollment cap has been reached, participants who were disenrolled shall be added to the waiting list.

(a) Voluntary disenrollment. Participants or representatives must provide notice to ~~SPD~~ the Department of intent to discontinue participation. The participant or the representative must meet with ~~SPD~~ the Department to reconcile remaining ICP cash payment either within 30 days of the date of disenrollment or before the termination date, whichever is sooner.

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

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

(B) Failure to maintain 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 or neglect or other abuse on the part of the employee provider or representative.

(C) Failure to purchase goods and services according to the 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 service plan) resulting in a negative consequence;

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

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

(5) INTERRUPTION OF SERVICES. When a participant is absent from the home for longer than 30 days due to illness or medical treatment, the ICP cash benefit shall be terminated. The cash benefit may resume upon 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, self-management, and twenty-four hour availability needs.

(c) Employee providers must complete a ~~criminal history~~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) Participant's relatives may be employed as employee providers.

(7) CASH BENEFIT.

(a) The cash benefit is determined based on the CA/PS assessment of need, the service plan, the 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 self-management task hours, and the twenty-four hour availability hours that the participant is eligible for as determined in the CA/PS assessment, at the rates according to the ~~SPD~~ Department's rate schedule.

(c) The following services, which are approved by the case manager and paid for by ~~SPD~~the Department, are excluded from ICP cash benefit:

(A) Community health supports;

(B) Contracted ~~non-medical waiver service~~community transportation;

(C) Home delivered meals; and

(D) Emergency response systems.

(d) The cash benefit shall include the employer's portion of required FICA, FUTA, and SUTA.

(e) The cash benefit shall be directly deposited into the 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 ~~SPD~~Department/AAA staff.

(b) The participant may amend the service budget as long as the amendments relate to meeting the 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 food stamps 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 home and community-based waivered or state plan 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 DHS 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 it can be 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~~home and community-based waivered and state plan service options and offer other alternatives if the participant is eligible.

(c) At least every six months, ~~SPD~~the Department/AAA staff must complete a service budget review to assure financial accountability and review service budget amendments.

(13) HEARING RIGHTS. ICP participants have contested case hearing rights as described in OAR chapter 461, division 025.

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

CHAPTER 411
DIVISION 40

HOME DELIVERED MEALS

411-040-0000 Home Delivered Meals
(Temporary Effective 7/1/2013 - 12/28/2013)

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

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

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

(4) The Department's unit staff are responsible for establishing, authorizing, purchasing, and monitoring a plan for home-delivered meals.

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

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

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

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

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

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

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

Stat. Auth.: ORS 410.070, 411.060, & 411.070
Stats. Implemented: ORS 410.070

CHAPTER 411
DIVISION 45

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

411-045-0010 Definitions
(Temporary Effective 7/1/2013 - 12/28/2013)

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

(2) Advance Directive -- A process that allows a person to have another person make health care decisions when he or she cannot make the decision and tells a doctor what life sustaining measures to take if he or she is near death.

(~~41~~3) ~~Seniors~~ Aging and People with Disabilities Division (~~S~~APD) -- A division within ~~DHS~~ the Department that is the designated State Unit on Aging (SUA) that also administers Medicaid's long-term care program. ~~SPD~~ APD is responsible for nursing facility and home and community-based ~~care~~ waivered or state plan services for eligible elderly and disabled individuals. ~~SPD~~ APD includes local offices and the AAAs who have contracted to perform specific functions of the licensing and enrollment processes. The term "Aging and People with Disabilities Division" is synonymous with "Seniors and People with Disabilities Division (SPD)".

(~~3~~4) Alternate ~~Care~~ Service Settings -- Residential 24 hour care facilities that include, but are not limited to, Residential Care Facilities, Assisted Living Facilities, Adult Foster Homes, and Nursing Facilities.

(~~4~~5) Americans with Disabilities Act (ADA) -- Federal law defining the civil rights of persons with disabilities. The ADA requires that reasonable accommodations be made in employment, service delivery, and facility accessibility.

(~~5~~6) Ancillary Services -- Those medical services that are medically appropriate to support a covered service under the PACE benefit package. A list of ancillary services and limitations is specified in DMAP's Ancillary Services Criteria Guide.

(~~6~~7) Appeal -- A PACE participant's action taken with respect to any instance where the PACE program reduces, terminates or denies a covered service.

(~~7~~8) Area Agency on Aging (AAA) -- An established public agency within a planning and service area designated under Section 305 of the Older American's Act that has responsibility for local administration of Department programs. AAAs contract with the Department to perform specific activities in relation to PACE programs including processing of applications for Medicaid and determining the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services.

(~~8~~9) Assessment -- The determination of a participant's need for covered services. It involves the collection and evaluation of data by each of the members of the Interdisciplinary Team pertinent to the participant's health

history and current problem(s) obtained through interview, observation, and record review. The Assessment concludes with one of the following:

(a) Documentation of a diagnosis providing the clinical basis for a written care plan; or

(b) A written statement that the participant is not in need of covered services for a particular condition.

(~~9~~10) Automated Information System (AIS) -- A computer system that provides information on the current eligibility status for participants under the Medical Assistance Program.

(11) Centers for Medicare and Medicaid (CMS) -- Formerly known as the Health Care Financing Administration (HCFA). The federal agency under the Department of Health and Human Services that is responsible for approving the PACE program and joining the state in signing an agreement with the PACE program once it has been approved as a provider under 42 CFR Part 460.

(12) Clinical Record -- The clinical record includes, but is not limited to, the medical, social services, dental, and mental health records of a PACE participant. These records include the Interdisciplinary Team's records, hospital records, and grievance and disenrollment records.

(13) Comfort Care -- The provision of medical services or items that give comfort or pain relief to a participant who has a terminal illness. Comfort care includes the combination of medical and related services designed to make it possible for a participant with terminal illness to die with dignity, respect, and with as much comfort as is possible given the nature of the illness. Comfort care includes but is not limited to, pain medication, palliative services, and hospice care including those services directed toward ameliorating symptoms of pain or loss of bodily function or to prevent additional pain or disability. These guarantees are provided pursuant to 45 CFR, Chapter XIII, 1340.15. Where applicable comfort care is provided consistent with Section 4751 OBRA 1990 -- Patient Self-Determination Act and ORS 127.505-127.660 and 127.800-127.897 relating to health care decisions. Comfort care does not include diagnostic or curative care for the primary illness or care focused on active treatment of the primary illness and intended to prolong life.

(14) Community Standard -- Typical expectations for access to the health care delivery system in the PACE participant's community of residence. Except where the community standard is less than sufficient to ensure quality of care, The Department requires that the health care delivery system available to PACE participants take into consideration the community standard and be adequate to meet the needs of PACE participants.

(15) Covered Services -- Those diagnoses, treatments, and services listed in OAR 410-141-0520. In addition, all services that would be covered by Medicare must be covered even if they fall below the currently funded line for the Oregon Health Plan. Covered services must also include those services listed in 42 CFR Sections 460.92 and 460.94.

(16) Dentally Appropriate -- Services that are required for prevention, diagnosis or treatment of a dental condition and that are:

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

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

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

(d) The most cost effective of the alternative levels of dental services that can be safely provided to a PACE participant.

(17) Dental Emergency Services -- Dental services provided for severe pain, bleeding, unusual swelling of the face or gums, or an avulsed tooth.

(~~19~~18) Department -- For the purposes of this rule, Department will indicate ~~those DHS~~the programs that contract with the PACE program: ~~Seniors~~ Aging and People with Disabilities (~~S~~APD)~~,~~ and the Oregon Health Authority, Addictions and Mental Health Division (AMH)~~,~~ and ~~the~~ Division of Medical Assistance Programs (DMAP).

(~~18~~19) DHS -- Department of Human Services (DHS) ~~Oregon's department that administers the Medicaid program and is comprised of Children, Adults and Families Division (CAF); Health Services (HS) (that includes DMAP and AMH); Seniors and People with Disabilities Division (SPD); Administrative Services (AS); and Finance and Policy Analysis (FPA)~~.

(20) Disenrollment -- The act of discharging a PACE participant from a PACE program. After the effective date of disenrollment a PACE participant is no longer authorized to obtain covered services from the PACE program.

(21) Emergency Services -- The health care and services provided for diagnosis and treatment of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

(22) Enrollment -- A process for the PACE program. A PACE participant's enrollment with a PACE program indicates that the PACE participant must obtain from, or be referred by, the PACE program for all covered services.

(23) Grievance -- A PACE participant's or the participant's representative's clear expression of dissatisfaction with the PACE program that addresses issues that are part of the PACE program's contractual responsibility. The expression may be in whatever form of communication or language that is used by the participant or the participant's representative but must state the reason for the dissatisfaction.

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

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

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

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

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

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

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

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

(g) Dietician and Pharmacist as indicated; and

(h) In addition to the positions listed above in paragraphs (25)(a)-(g), the IDT must include the PACE Center Manager, the Home Care Coordinator, Personal Care Attendant and the Driver or Transportation Coordinator.

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

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

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

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

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

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

(28) Medicare -- The federal health insurance program for the aged and disabled administered by the Health Care Financing Administration under Title XVIII of the Social Security Act.

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

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

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

(32) Addictions and Mental Health Division (AMH) -- The division within the ~~Department of Human Services~~Oregon Health Authority responsible for the administration of the state's mental health and addiction services programs.

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

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

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

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

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

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

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

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

(36) Participating Provider -- An individual, facility, corporate entity, or other organization that supplies medical, dental, or mental health services or items who have agreed to provide those services or items and to bill in accordance with a signed agreement with a PACE program.

(37) Preventive Services -- Those services as defined under Expanded Definition of Preventive Services in OAR 410-141-0480 and 410-141-0520.

(38) Primary Care Provider (PCP) -- A medical practitioner who has responsibility for supervising and coordinating initial and primary care within his or her scope of practice for PACE participants. Primary Care Providers initiate referrals for care outside their scope of practice that may include

consultations and specialist care, and assure the continuity of medically or dentally appropriate care.

(39) Quality Improvement -- Quality improvement is the effort to improve the level of performance of a key process or processes in health and long term care. A quality improvement program measures the level of current performance of the processes, finds ways to improve the performance and implements new and better methods for the processes. Quality Improvement includes the goals of quality assurance, quality control, quality planning and quality management in health care. Quality of care reflects the degree to which health services for individuals and populations increases the likelihood of desired health outcomes and is consistent with current professional knowledge.

(40) Representative -- A person who can assist the PACE participant in making administrative related decisions such as, but not limited to, completing enrollment application, filing grievances, and requesting disenrollment. A representative may be, in the following order of priority, a person who is designated as the PACE participant's health care representative, a court-appointed guardian, a spouse, or other family member as designated by the PACE participant, the Individual Service Plan Team (for individuals with intellectual or developmentally disabled clients disabilities), an SPDDepartment/AAA case manager or other DHS Department designee. This definition does not apply to health care decisions unless the representative has legal authority to make such decisions.

(4241) Service Area -- The geographic area defined by Federal Information Processing Standards (FIPS) codes, or other criteria determined by the Department, in which the PACE program has agreed to provide services under the Oregon PACE program Regulations and the Federal PACE Regulations 42 CFR Part 460. This geographic area is defined in the PACE contract with the Department.

(1042) Care Service Plan -- An individualized, written plan that addresses all relevant aspects of a participant's health and socialization needs that is developed by the Interdisciplinary Team with the participant and the participant's representative involvement. It is based on the findings of the participant's assessments and defines specific service and treatment goals and objectives; proposed interventions; and the measurable outcomes to

be achieved. It is reviewed at least every four months or as indicated by a change in the participant's condition. The term "Service Plan" is synonymous with "Care Plan".

(43) Triage -- Evaluations conducted to determine whether or not an emergency condition exists, and to direct the DMAP member to the most appropriate setting for medically appropriate care.

(44) Urgent Care Services -- Covered services required to prevent a serious deterioration of a PACE participant's health that results from an unforeseen illness or an injury and for dental services necessary to treat such conditions as lost fillings or crowns. Services that can be foreseen by the individual are not considered urgent services.

(45) Valid Claim -- An invoice received by the PACE program for payment of covered health care services rendered to an eligible PACE participant that:

(a) Can be processed without obtaining additional information from the provider of the service or from a third party;

(b) Has been received within the time limitations prescribed in these rules; and

(c) A "valid claim" is synonymous with the federal definition of a "clean claim" as defined in 42 CFR 447.45(b).

(46) Valid Pre-Authorization -- A request, received by the PACE program for approval of covered health care services provided by a non-participating provider to an eligible ~~client~~individual, that can be processed without obtaining additional information from the provider of the service or from a third party.

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

411-045-0050 Enrollment
(Temporary Effective 7/1/2013 - 12/28/2013)

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

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

(b) Be 55 years of age or older;

(c) Be able to be maintained in a community-based setting at the time of enrollment without jeopardizing his or her health or safety or the health and safety of others;

(d) Be determined by the local ~~SPD~~Department/AAA agency to need the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services in accordance with OAR 411-015-0000 - 411-015-0100 Service Priority, Current Limitations and Eligibility for Nursing Facility or home and ~~C~~community-~~B~~based ~~Care~~ waivered or state plan ~~S~~services;

(e) Be Medicaid eligible or be willing to pay private fees; and

(f) Be willing to abide by the provision that requires enrollees to receive all health and long term care services exclusively from the PACE program and its contracted or referred providers.

(2) The criteria for determining that an individual cannot live safely in the community and thereby may be denied enrollment is as follows:

(a) The individual demonstrates imminent danger to self or others in accordance with the definition in OAR 411-015-0005;

(b) There is evidence in the individual's clinical record that shows he or she has been repeatedly placed in appropriate care settings and, despite medically appropriate treatment, placement has resulted in frequent hospitalizations or failed placements; or

(c) At the time of application, the individual is determined to be eligible for enhanced care services or long term care at Oregon State Hospital by either the enhanced care Services Coordinator or the OSH Gero-Psychiatric Outreach Team.

(d) At the time of application, the individual has a physician documented condition that meets the criteria for Medicare skilled care and does not appear to be able to be discharged to the community within the next 30 days.

(e) At the time of application, the applicant lives in their own home and wishes to remain there but requires 24-hour care to remain safely in their home.

(3) If either the PACE program or the local ~~SPD~~Department/AAA case manager has concerns about the safety of a potential enrollee, a case conference can be convened to review the case with outside consultants as needed for further evaluation.

(4) Enrollment/Screening and Intake:

(a) ~~SPD~~Department/AAA staff will process the application for Medicaid services and determine the level of care required under Oregon's State Medicaid Plan for coverage of nursing facility services. ~~SPD~~Department/AAA staff will follow appropriate PACE enrollment protocols as outlined in the SPD/AAA Policy Manuals.

(b) ~~SPD~~Department/AAA staff will conduct initial screening and intake, including providing assistance in completing the application and obtaining relevant information.

(c) The Department will provide for the calculation of any applicable spend-down liability and for post-eligibility treatment of income for Medicaid participants in the same manner as the Department treats spend-down liability and post-eligibility income for individuals receiving home and community-based waivered or state plan services ~~under the Home and Community Based Care Waiver~~ (OAR 461-160-0620).

(d) The ~~SPD~~Department/AAA staff will forward intake information of potential enrollees to the PACE program staff who will assess the applicant's appropriateness for enrollment in the PACE program in accordance with these rules and the requirements of 42 CFR 460.152. Potential enrollees may be denied enrollment by the PACE program if it determines the ~~client~~ individual would not be able to be maintained in a community based setting without jeopardizing his or her health or safety or the health and safety of others.

(e) If the potential enrollee or his or her representative is in disagreement with the PACE program's decision not to enroll the person, he or she may file an appeal with the Department.

(f) All letters to applicants regarding denial of enrollment by the PACE program must include the reason for the denial and the applicants appeal rights. This letter along with documentation of pertinent information related to the decision must be forwarded to the Department for review.

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

CHAPTER 411
DIVISION 48

LONG TERM CARE COMMUNITY NURSING

411-048-0150 Purpose
(Temporary Effective 7/1/2013 - 12/28/2013)

(1) The rules in OAR chapter 411, division 048 establish standards and procedures for Medicaid enrolled providers who provide long term care community nursing services. Long term care community nursing services provide ongoing registered nurse (RN) services to eligible individuals who are receiving Medicaid funded home and community-based waivered or state plan services in a home based or foster home setting.

(2) Long term care community nursing services provide:

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

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

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

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

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

411-048-0160 Definitions
(Temporary Effective 7/1/2013 - 12/28/2013)

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

(2) "Abuse" means:

(a) Abuse of a child:

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

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

(b) Abuse of an adult or older adult:

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

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

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

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

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

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

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

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

(8) "CDDP" means the Community Developmental Disability Program responsible for the planning and delivery of services for individuals with

developmental disabilities according to OAR chapter 411, division 320. A CDDP operates in a specific geographic service area of the state under a contract with the Department, local mental health authority, or other entity as contracted by the Department.

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

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

(11) "Department Approved Form" means forms used by registered nurses and case managers to support these rules. The Department maintains these documents on the Department's website (http://www.oregon.gov/dhs/spd/pages/provtools/nursing/forms.aspx). Printed copies may be obtained by contacting the Department of Human Services, ATTN: Rule Coordinator, 500 Summer Street NE, E10, Salem, OR 97301.

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

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

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

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

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

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

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

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

(17) "Home" means a non-licensed setting where an individual is receiving home and community-based waivered or state plan services.

~~(18) "Home and Community Based Waivered Services" mean the services approved and funded by the Centers for Medicare and Medicaid Services for eligible individuals who are aged and physically disabled and for eligible individuals with intellectual disabilities and developmental disabilities in accordance with section 1915(c) under Title XIX of the Social Security Act.~~

(~~19~~18) "Home Health Agency" has the meaning given that term in ORS 443.005.

(~~20~~19) "Individual" means a person eligible for community nursing services under these rules.

(~~21~~20) "In-Home Care Agency" has the meaning given that term in ORS 443.305.

(~~22~~21) "Local Office" means the Department office, Area Agency on Aging, or Community Developmental Disability Program responsible for Medicaid services including case management, referral, authorization, and oversight of long term care community nursing services in the region where the individual lives and where the community nursing services are delivered.

(~~23~~22) "Long Term Care Community Nursing Services (Community Nursing Service)" mean, for the purpose of these rules, the nursing services provided under these rules to individuals living in a home based or foster home setting where the monthly home and community-based waivered or

state plan services rate does not include nursing services. Long term care community nursing services are a distinct set of services that focus on an individual's chronic and ongoing health and activity of daily living needs. Long term care community nursing services include an assessment, monitoring, delegation, teaching, and coordination of services that addresses an individual's health and safety needs in a Nursing Service Plan that supports individual choice and autonomy. The requirements in these rules are provided in addition to any nursing related requirements stipulated in the licensing rules governing the individual's place of residence.

(~~24~~23) "Medication Review" means a review focused on an individual's medication regime that includes examination of the prescriber's orders and related administration records, consultation with a pharmacist or the prescriber, clarification of PRN (as needed) parameters, and the development of a teaching plan based upon the needs of the individual or the individual's caregiver. In an unlicensed setting, the medication review may include observation and teaching related to administration methods and storage systems.

(~~25~~24) "Nursing Assessment" means one of the following assessments selected by the registered nurse based on an individual's need and situation:

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

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

(~~26~~25) "Nursing Service Plan" means the plan that is developed by the registered nurse based on an individual's initial nursing assessment, reassessment, or updates made to a nursing assessment as a result of monitoring visits.

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

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

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

(~~27~~26) "OSBN" means the Oregon State Board of Nursing. OSBN is the agency responsible for regulating nursing practice and education for the purpose of protecting the public's health, safety, and well-being.

(~~28~~27) "Rate Schedule" means the communication tool issued by the Department to transmit rate changes to partners, subcontractors, and stakeholders. The Department maintains this document on the Department's website (http://www.oregon.gov/dhs/spd/provtools/rateschedule.pdf). Printed copies may be obtained by contacting the Department of Human Services, ATTN: Rule Coordinator, 500 Summer Street NE, E10, Salem, OR 97301.

(~~29~~28) "RN" means a registered nurse licensed by the Oregon State Board of Nursing. An RN providing long term care community nursing services under these rules is either an independent contractor who is an enrolled Medicaid provider or an employee of an organization that is an enrolled Medicaid provider.

(~~30~~29) "These Rules" mean the rules in OAR chapter 411, division 048.

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

411-048-0170 Eligibility and Limitations
(Temporary Effective 7/1/2013 - 12/28/2013)

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

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

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

(A) Long term supports for children with developmental disabilities as described in OAR chapter 411, division 308;

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

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

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

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

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

(G) 1915C Nursing Facility Waiver; or

(H) State Plan K Community First Choice;

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

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

(2) LIMITATIONS.

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

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

(B) An individual enrolled in a brokerage, Independent Choices, or other support services not funded by home and community-based waivered or state plan services; or

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

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

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

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

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

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

CHAPTER 411
DIVISION 65

SPECIALIZED LIVING SERVICES CONTRACTS

411-065-0000 Purpose
(Temporary Effective 7/1/2013 - 12/28/2013)

The purpose of these rules is to establish standards for specialized living service contracts. The standards provide an enhanced continuum of quality care in a home-like environment for specific target groups who are eligible for a live-in attendant, but because of special needs, cannot live independently or be served in other community-based care facilities and who would otherwise require nursing facility care. Services provided to residents in the Specialized Living Services Program are those covered in Oregon's ~~Title XIX Community Based Care Waiver Programs~~Home and Community-based Waiver or State Plan, which may include specific services required because of physical, intellectual or behavioral limitations in meeting self-care needs.

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

CHAPTER 411
DIVISION 70

NURSING FACILITIES/MEDICAID – GENERALLY AND REIMBURSEMENT

Nursing Facilities/Medicaid – Generally

411-070-0033 Post Hospital Extended Care Benefit
(Temporary Effective 7/1/2013 - 12/28/2013)

(1) The post hospital extended care benefit (OAR 410-120-1210(3)(a)(F)) is an Oregon Health Plan benefit that consists of a stay of up to 20 days in a nursing facility to allow discharge from hospitals.

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

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

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

(b) Not be Medicare eligible;

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

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

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

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

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

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

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

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

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

(5) Individuals eligible for the 20 day post-hospital extended care benefit are not eligible for long term care nursing facility or home and community-based waivered or state plan services unless the individual meets the eligibility criteria in OAR 411-015-0100 or OAR 411-320-0020(28).

Stat. Auth.: ORS 410.070 & ORS 414.065
Stats. Implemented: ORS 410.070 & ORS 414.065