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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

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ARCHIVES DIVISION
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CHAPTER 411
DEPARTMENT OF HUMAN SERVICES
AGING AND PEOPLE WITH DISABILITIES AND DEVELOPMENTAL DISABILITIES

FILING CAPTION: APD: Adopting rules to implement the Oregon Project Independence-Medicaid (OPI-M) program

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 10/25/2024 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
Kristina Krause
Rules Coordinator

HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 10/22/2024
TIME: 9:00 AM - 10:00 AM
OFFICER: Staff

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 1-669-254-5252
CONFERENCE ID: 1605329680
SPECIAL INSTRUCTIONS:
This rule hearing is for people to provide comments about the proposed adoptions of rules in OAR chapter 411, divisions 14 and 16 related to Oregon Project Independence-Medicaid. If you wish to attend the rule hearing, please join no later than 15 minutes after the hearing has started. The rule hearing will close after 30 minutes if no one attends or wants to provide comments.

If you wish to provide comments about the proposed rules, please register in advance at the following link: https://www.zoomgov.com/meeting/register/vJItcuqqpz0iGrixN4a-ZKt5XJA_YEpx4Yo

After registering, you will receive a confirmation email containing information about joining the rule hearing. If you need help signing up, please call the APD Rules Coordinator, Kristina Krause, at 503-339-6104 or send an email directly to Kristina.R.Krause@odhs.oregon.gov.

Everyone has a right to know about and use ODHS programs and services. ODHS supplies free help. Some examples of the free help ODHS can supply are sign language and spoken language interpreters, written materials in other languages, braille, large print, audio, and other formats. If you need clarification on these rules, help, or have questions, please contact Naomi Sacks at 503-385-7168, or by email at Naomi.E.Sacks@odhs.oregon.gov at least five business

days before the meeting. ODHS accepts calls from all forms of relay service.

NEED FOR THE RULE(S)

Oregon's Department of Human Services Office of Aging and People with Disabilities (APD) was approved for a federal demonstration waiver creating a new program, Oregon Project Independence-Medicaid (OPI-M) on February 13, 2024. To implement the new program, temporary rules were filed effective May 31, 2024, which expire November 26, 2024. These permanent rules are necessary to continue the program throughout the waiver demonstration period and beyond if the demonstration is successful.

The OPI-M program was designed to draw federal funding to support expanding access to in-home services for people with caregiving needs. The intent was to build on the existing state funded Oregon Project Independence (OPI) program which provides limited in-home services to keep individuals in their own homes, helping them to maintain their health, safety and independence while preventing the need for more extensive, costly care and the need for full Medicaid services.

The OPI-M program seeks to accomplish this goal by reducing Medicaid access barriers allowing people with higher incomes and greater resources to qualify, eliminating estate claims and cost shares, and allowing more services and new caregiver support benefits than either the OPI program or traditional Medicaid long term services and supports.

Along with the new OAR chapter 411, division 014 rules which cover OPI-M program eligibility, these rules are needed to provide structure for the program including the roles and responsibilities of the case manager and eligible individual, the service planning process and the services that are available through the program. The rules also help ensure compliance with the federal waiver allowing APD to run the program.

While there was no specific legislation that created the program, exploring a way to better sustain the existing OPI program was required in a budget note to House Bill 5026 during the 2019 legislative session. The budget note required APD and the Oregon Health Authority (OHA) to convene an advisory group to explore, "...opportunities to obtain federal funding for the Oregon Project Independence and family caregiver respite programs,..." and requiring a report back to the House and Senate Human Services Committees by Dec. 2020, and the report back in 2021 to the House and Senate Committees (extension granted because of the pandemic) in which the committees did not object to the design or the intent to apply for the federal waiver. Links to the budget notes and Committee reports are below.

The OPI-M program is needed to address demographic shifts that reveal Oregon's rapidly growing population of older adults and an increasing demand for affordable long-term services and supports. OPI-M, by reducing barriers to services and providing an extensive array of services and supports (including new supports for unpaid caregivers), allows Oregon to leverage federal dollars to better meet Oregonians' needs and realize the vision of Oregon Revised Statute 410 for older adults and people with disabilities to live lives of health, honor, dignity and maximum freedom and independence.

The rules are needed to operate the program and be in compliance with the federal waiver.

Other changes may be made to OAR chapter 411, division 016 to correct grammatical errors, ensure consistent terminology, address issues identified during the public comment period, and to improve the accuracy, structure, and clarity of the rule.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

Oregon Project Independence -Medicaid Waiver website
https://www.oregon.gov/odhs/providers-partners/seniors-disabilities/Pages/1115-demonstration-waiver.aspx

Oregon 1115 Waiver Standard Terms & Conditions
https://www.oregon.gov/odhs/providers-partners/seniors-disabilities/Documents/opi-standard-terms-conditions.pdf

Budget Note: HB 5026 (2019), page 13:
https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureAnalysisDocument/52097

House Human Services Report back, February 3, 2021:
https://olis.oregonlegislature.gov/liz/2021R1/Committees/HHS/2021-02-03-15-15/Agenda

Senate Human Services Report back, April 20, 2021:
https://olis.oregonlegislature.gov/liz/2021R1/Committees/SHSMHR/2021-04-20-15-15/Agenda

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STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

OPI-M is expected to have a positive effect on communities that have been impacted by racism and other forms of social discrimination and oppression. We believe the programs will offer many significant advantages for communities of color, Tribes in Oregon, immigrant communities, and the LGBTQIA2S+ community. Some positive impacts include:

- Consumers are served in their homes. Data show that in Medicaid LTSS, communities of color access in-home services at a higher rate than other populations in Oregon.
- Consumers participating in OPI-M will not be subject to estate recovery. This may have a positive impact on mitigating institutionalized and historical gaps in household wealth experienced by communities of color in Oregon and the United States. The program will not contribute to intergenerational poverty.
- Consumers supported by family or other unpaid caregivers have access to services to sustain this caregiver relationship. This would be impactful for intergenerational families who are more prevalent among communities of color, immigrant communities, and rural communities than the overall population.
- Original OPI and the OAA family caregiver programs will be preserved, and these programs can serve consumers who otherwise are not eligible for federally matched programs under Medicaid authority because of citizenship or legal residency requirements.

As per the Special Terms and Conditions (STCs) of the waiver with the Centers for Medicare and Medicaid Services (CMS), we will periodically review the demographics of consumers utilizing these services. We will also review the capacity indicators we have for culturally and linguistically responsive services, and we will have quality indicators which also include consumer survey data (through NCI-AD) to measure consumer satisfaction and the consumer's perspective on the quality of services and supports.

As mentioned above, we are designing the policies for these new programs informed by the data we have on impacted communities. Impacted communities are more likely than the overall population to access in-home services, be negatively impacted by estate recovery, and live in intergenerational families. As we implement these programs, we will use program data (utilization data, analysis of outreach and communication, survey data) to check these assumptions of the program design that would benefit affected communities more positively than Medicaid LTSS and other existing programs. If the data show continued trends of adverse impact, we will use the findings and the input from impacted communities to modify and change the policies and rules of these programs as input and as data indicate.

As the program just opened on June 1, 2024, with a rolling implementation starting with individuals currently

underserved, we do not yet have data to include in this statement. Full public opening is expected in March 2025. We will be collecting and monitoring over time.

One group of the public may be negatively impacted by OPI-M. Older adults and people with disabilities who are non-citizens will not be eligible for OPI-M as OPI-M is funded in part through Medicaid and citizenship is required for Medicaid eligibility. The existing OPI program will continue with a very reduced budget and can serve non-citizens. Since much of the OPI budget will be shifted to cover the state share costs for OPI-M, there will be less funding available to support people who only qualify for OPI, including non-citizens. APD plans to mitigate this impact by prioritizing non-citizens in the use of OPI funding.

FISCAL AND ECONOMIC IMPACT:

The Fiscal and Economic Impact is stated below in the Department's statement of Cost of Compliance.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s).

State Agencies: The Department estimates that there will be a fiscal and economic impact on the Oregon Department of Human Services (ODHS), Office of Aging and People with Disabilities (APD), and a minor fiscal and economic impact on the Oregon Health Authority (OHA).

For APD, the impact includes costs to implement and administer the services and supports for Oregon Project Independence- Medicaid (OPI-M). Costs include:

- Staffing at local offices for eligibility determination for the program;
- Staffing and support in Central Office for financial eligibility determination;
- Central Office staffing for program design and implementation, including rule making and coordination, training, operations and program guidance, systems design and changes, and program reporting and evaluation activities;
- Costs associated with workload for approval of certain services requiring Central Office or local APD office approval;
- Program costs for production and distribution of materials for staff support, consumer information, and general public information; and
- Possible ongoing staffing costs for service case management depending on workload analysis as OPI-M is implemented.

For OHA, there is a minor impact for costs associated with program administration with the federal Centers for Medicare and Medicaid Services (CMS) as the single state Medicaid agency.

Regarding this fiscal and economic impact to State Agencies, OPI-M is an 1115 Medicaid Demonstration that is budget neutral, and the costs associated with the program will be paid with approximately 60 percent of federal funds and 40 percent state matching funds.

Units of Local Government: The Department estimates there will be a fiscal and economic impact on local Area Agencies on Aging (AAAs) and other local government partners within the Aging and Disability Resource Connections network. This impact includes:

- Staffing for Type B Transfer AAAs for both eligibility determination and service case management for consumers in the OPI-M program;
- Staffing for workload associated with managing intakes of applications;
- Staffing for Type A AAAs for ongoing service case management for consumers determined eligible by APD;
- Staffing to cover workload associated with provider payment processing;
- Costs associated with approval of certain services;
- Administrative costs associated with workload for reporting, record keeping, quality assurance and compliance;
- ADRC costs associated with increased workload related to consumer intakes, information, and referrals.

Regarding this fiscal and economic impact to Units of Local Government, OPI-M is an 1115 Medicaid Demonstration that is budget neutral, and the costs associated with the program will be paid with approximately 60 percent of federal funds and 40 percent state matching funds.

Consumers: The Department estimates no fiscal or economic impact on most consumers except non-citizens. As described above, non-citizens will not qualify for OPI-M but may access services through OPI. OPI has a more limited budget so may have a wait list, has fewer types of services, has less service available per individual and has a cost share all of which could drive costs up for non-citizens if they have to pay for care unavailable otherwise.

Providers: The Department estimates a positive fiscal or economic impact on providers attributed to the increasing services and supports provided by OPI-M to consumers.

Public: The Department estimates there will be no fiscal or economic impact on the public.

(2) Effect on Small Businesses:
(a) Estimate the number and type of small businesses subject to the rule(s);

There is no estimate on the number of small businesses subject to these rules at this time. Small businesses affected by these rules include In-Home Care Agencies, Home Delivered Meals providers, Adult Day Services providers, vendors for Chore Services, Home Modifications, Assistive Technologies, and Community Transportation, as well as providers for health and wellness programs, unpaid caregiver training and supports, and other services.

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);

The proposed changes impact providers as described above in the Department's statement of cost of compliance – there is a minimal impact on reporting, recordkeeping, and administrative activities as the OPI-M program does not provide additional activities from other existing programs in which small business providers participate.

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

The proposed changes impact providers as described above in the Department's statement of cost of compliance, with no minimal fiscal or economic impact to small businesses, but an estimated positive fiscal and economic impact by the

increase of consumers that these providers serve.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

A small business, or representative of a small business, as defined in ORS 183.310 participated on the Administrative Rule Advisory Committee. Small businesses will also be included in the public review and comment period.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
411-016-0000, 411-016-0005, 411-016-0010, 411-016-0020, 411-016-0025, 411-016-0030, 411-016-0040, 411-016-0050, 411-016-0075, 411-016-0080, 411-016-0090, 411-016-0100, 411-016-0110, 411-016-0120, 411-016-0130, 411-016-0140, 411-016-0150, 411-016-0160, 411-016-0170, 411-016-0180, 411-016-0190, 411-016-0200, 411-016-0210, 411-016-0300

ADOPT: 411-016-0000

RULE SUMMARY: Defines purpose of the Oregon Project Independence-Medicaid program

CHANGES TO RULE:

411-016-0000
Purpose
The purpose of the Oregon Project Independence-Medicaid program is to:¶
(1) Provide limited, non-medical assistance to delay or prevent the need for full Medicaid long term services and supports under Oregon's 1915(c) waiver authority or any other state plan authorities; ¶
(2) Optimize and maintain an eligible individual's personal resources and natural supports;¶
(3) Provide access to limited, preventive in-home services to older adults and adults with disabilities who require assistance with activities of daily living; and¶
(4) Develop and maintain the ability of individual, using natural supports, to meet their personal needs and support the health and well-being of unpaid caregivers to sustain caregiving relationships.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.070

ADOPT: 411-016-0005

RULE SUMMARY: Defines key terms used in the program rules

CHANGES TO RULE:

411-016-0005
Definitions
Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 016:¶
(1) "Activities of Daily Living (ADL)" mean those personal functional activities required by an individual for continued well-being, which are essential for health and safety and defined in OAR 411-015-0006. Activities include bathing and personal hygiene, cognition, dressing and grooming, eating, elimination, and mobility.¶
(2) "Adult" means any person at least 18 years of age.¶
(3) "Adult Day Services (ADS) Program" means a community-based group program designed to meet the needs of adults needing assistance with ADLs described in OAR chapter 411, division 066. ¶
(4) "Alternative Service Resources" means other possible resources for the provision of services to meet an individual's needs. Alternative service resources include, but are not limited to, natural supports, risk intervention services, or other community supports. Alternative service resources are not paid by Medicaid.¶
(5) "Area Agency on Aging (AAA)" means the Department designated agency charged with the responsibility to provide a comprehensive and coordinated system of services to older adults and adults with disabilities in a planning and service area. The term Area Agency on Aging (AAA) is inclusive of both Type A and Type B AAAs as defined in ORS 410.040 to 410.300.¶
(a) "Type A Area Agency on Aging" means an Area Agency on Aging for which either the local government or the area agency board does not agree to accept local administrative responsibility for Title XIX Medicaid, except OPI-M; and that provides a service to adults.¶
(b) "Type B Area Agency on Aging" means an Area Agency on Aging:¶
(A) For which the local government agrees to accept local administrative responsibility for Title XIX Medicaid;¶
(B) That provides a service to older adults or to older adults and persons with disabilities who require services similar to those required by older adults; and¶
(C) Are one of two models of Type B AAA's-Type B Contract or Type B Transfer: ¶
(i) Type B Contract- Staff are employed by the AAA and only administer Older Americans Act, Oregon Project Independence and Oregon Project Independence-Medicaid services case management services.¶
(ii) Type B Transfer- Staff are employed by the AAA and administer all of the following programs: Medicaid, financial services, Supplemental Nutrition Assistance Program, adult protective services, regulatory programs, Older Americans Act, Oregon Project Independence and all Oregon Project Independence-Medicaid services.¶
(6) "Assistive Devices" means any category of durable medical equipment, mechanical apparatus, electrical appliance, instrument of technology, service animal, general household items, or furniture used to assist and enhance an individual's independence in performing any activity of daily living.¶
(7) "Assistive Technology" means any item, piece of equipment, technology, system, whether acquired commercially, modified, or customized, that is used to achieve, increase, maintain, or improve the functional capabilities of an individual, that provides additional security and support to an individual, replaces the need for human interventions or enables an individual to self-direct their care and maximize their independence. Training on using the technology should be offered to the individual.¶
(8) "Assisted Transportation" means escort services that aid an individual who has difficulties (physical or cognitive) using regular vehicular transportation and includes those services and supports provided so that the individual may access their local community to engage in services necessary to meet their Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). Assisted Transportation must be prior authorized by the Services Case Manager as part of a comprehensive service plan. ¶
(9) "Care Setting" means a Medicaid contracted facility where a Medicaid eligible individual resides and receives services. Care settings include adult foster homes, residential care facilities, assisted living facilities, specialized living contracted residences, and nursing facilities.¶
(10) "Caregiver Education and Training" means education and training programs and services to increase an unpaid caregiver's skills in providing care and supports unique to the consumer receiving unpaid caregiver services.¶
(11) "Case Management and Service Coordination" means a service designed to individualize and integrate social and health care options with an individual being served. The goal of service coordination is to provide access to an array of service options to assure appropriate levels of service and to maximize coordination in the service delivery system.¶
(12) "Chore Services" means assistance such as heavy housework, yard work, or sidewalk maintenance provided

on an intermittent or one-time basis to assure health and safety.¶
(13) "Client Assessment and Planning System (CA/PS)" means:¶
(a) The single-entry data system used for -¶
(A) Completing a comprehensive and holistic assessment;¶
(B) Surveying an individual's physical, mental, and social functioning; and¶
(C) Identifying risk factors, individual choices and preferences, and the status of service needs.¶
(b) The CA/PS documents the level of need and calculates the individual's service priority level in accordance with these rules and accommodates individual participation in service planning.¶
(14) "Community Caregiver Supportive Services" means supports and services that assist the individual and their unpaid caregivers to sustain their caregiving relationship and natural support systems. These supportive services directly benefit the individual by sustaining the unpaid caregiver's health, improving the unpaid caregiver's wellbeing and reducing stress. This may help prevent abuse, neglect and transitions to more intensive levels of care. ¶
(15) "Community Transportation" means non-medical transportation provided by a service provider with a Medicaid provider number and prior authorized as part of an OPI-M service plan by a Services Case Manager.¶
(16) "Conflict-free Case Management" means that assessment and coordination of services are separate from the delivery of services, with the goal to limit any conscious or unconscious bias a care manager or agency may have, and ultimately promote the individual's choice and independence.¶
(17) "Conflict of Interest" means a situation exists in which a person is in a position to derive personal benefit from their actions or decisions made in their relationship or role with another individual. Note: It is always considered a conflict of interest if a paid provider is making/managing service plan/care-related decisions on behalf of a consumer (meaning the provider is acting as the Consumer's authorized CE or Client Representative, OAR 411-031-0020(21), 411-031-0040(8)(b)(N), and 411-031-0050(3)(p)).¶
(18) "Cost Effectiveness or cost-effective" means being responsible and accountable with Department resources. This is accomplished by offering less costly, unduplicated alternatives when providing choices that adequately meet an individual's service needs. Those choices consist of all available services under these rules, the utilization of assistive devices, natural supports, home modifications, housing accommodations and alternative service resources not paid for by the Department. Cost effectiveness means that more than one service is not authorized to meet the same needs.¶
(19) "Department" means the Oregon Department of Human Services (ODHS).¶
(20) "Electronic Visit Verification (EVV)" means an interface that records the homecare worker's start time, end time, and geolocation for a service delivered by a homecare worker in real time.¶
(21) "Emergency Response Systems" mean a type of electronic back-up system that secures help for individuals in an emergency; ensures a consumer's safety in the community; and includes other reminders that help an individual with their activities of daily living and instrumental activities of daily living. This includes alert systems, units that are worn by the individual or are in the individual's home for the purpose of generating notification that an emergency has or may occur.¶
(22) "Evidence-Based Health Promotion" means individual or group programs that meet the requirements for the U.S. Administration on Community Living's Evidence-Based Definition or is an "evidence-based program" by any operating division of the U.S. Department of Health and Human Services (HHS) and is shown to be effective and appropriate for older adults.¶
(23) "Fiscal Intermediary" means a state contracted provider who manages payments, makes payments, and accounts for expenditures made on behalf of the consumer as directed by the consumer or authorized representative and approved by the case manager.¶
(24) "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.¶
(25) "Health and Safety" means the essential actions necessary to meet an individual's health care, food, shelter, clothing, personal hygiene and other care needs without which serious physical injury or illness is likely to occur that would result in hospitalization, death or permanent disability.¶
(26) "Home" or "In-Home" means a setting that exhibits the characteristics described in OAR 411-030-0033(2)(a) - (d). ¶
(27) "Home Delivered Meals" for the purpose of these rules means meals that are delivered by a home delivered meals provider with a Medicaid provider number to an eligible participant in their own home or apartment and meeting the criteria in OAR 411-040-0035.¶
(28) "Home Modifications" mean the changes made to adapt living spaces to meet specific service needs of eligible individuals with physical limitations to maintain their health, safety, and independence.¶
(29) "Homecare Worker" means a provider, as described in OAR 411-031-0040 (Consumer-Employed Provider Program), that is directly employed by an individual to provide hourly services to the eligible individual. The term

homecare worker does not include an employee of an in-home care agency who is providing in-home services. ¶
(30) "Household" means a group of individuals that live together within the same dwelling. For homeless individuals, the household consists of the individuals who consider themselves living together.¶
(31) "In-Home Care Agency" or "IHCA" means an agency as defined in OAR 333-536-0005 (Definitions) that is primarily engaged in providing in-home care services for compensation to an individual in that individual's place of residence. "In-home care agency" does not include a home health agency or portion of an agency providing home health services.¶
(32) "In-Home Support and Personal Care Services" mean those services that meet an individual's assessed need related to activities of daily living and instrumental activities of daily living provided in the individual's home or family's home.¶
(33) "Individual" means an older adult or an adult with a disability applying for or eligible for services. The term "individual" is synonymous with "consumer" or "client".¶
(34) "Informed choices" or "Informed decisions" means the individual is independent in decision making as defined in OAR 411-015-0006(3)(f)(B) or has the assistance of a representative to assist them in decision making.¶
(35) "Instrumental Activities of Daily Living (IADL)" means those activities, other than activities of daily living, required by an individual to continue independent living. The definitions and parameters for assessing needs in IADL are identified in OAR 411-015-0007.¶
(36) "Long Term Care Community Nursing Services" mean 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.¶
(37) "Natural Supports" or "Natural Support System" means resources and supports (e.g., relatives, friends, significant others, neighbors, roommates, or the community) who are willing to voluntarily provide services to an individual without the expectation of compensation. Natural Supports are identified in collaboration with the individual and the potential natural support. The Natural Support is required to have or be able to readily acquire the skills, knowledge and ability to provide the needed services and supports. ¶
(38) "Older Adult" means any person at least 60 years of age.¶
(39) "Oregon Project Independence- Medicaid (OPI-M)" means the services approved and funded by the Centers for Medicare and Medicaid Services (CMS) for eligible individuals in accordance with the 1115 demonstration waiver for the Oregon Project Independence-Medicaid program and including the services defined in these rules.¶
(40) "Pay Period" means specific two consecutive workweeks, defined by the Department, for a total of 14 calendar days. ¶
(41) "Person-centered service planning" means a process for selecting and organizing the services and supports with an eligible individual which includes the personal preferences and choices of the individual.¶
(42) "Representative" is the person appointed by the individual or a person with longstanding involvement in assuring the individual's health, safety and welfare. For the purposes of these rules, representative also includes legal representatives and designated representatives. ¶
(43) "Service Priority Level (SPL)" means the order in which Department and AAA Type B transfer staff identify individuals eligible for a nursing facility level of care, Oregon Project Independence, Oregon Project Independence-Medicaid or Medicaid home and community-based services in OAR 411-015-0010. A lower SPL number indicates greater or more severe functional impairment. The number is synonymous with the SPL.¶
(44) "Services Case Manager" means an employee of a AAA or the Department who is providing OPI-M conflict-free case management. The Services Case Manager provides person-centered service planning for and with eligible individuals. This includes authorizing and implementing an individual's service plan and monitoring service provision as described in OAR chapter 411, division 016. ¶
(45) "Supports for Consumer Direction" means activities to empower, train and inform individuals receiving in-home services regarding their rights, roles and responsibilities as employers of homecare workers, to empower the consumer to advocate for themselves in services and resources outside their service plan, such as health care and behavioral health services, housing, and transportation, and to help consumers manage their person-centered service plan, their personal goals and life experiences, ensuring the consumer's health, safety, and overall wellbeing.¶
(46) "Title XIX Medicaid" means a joint federal and state funded program for medical assistance established by Title XIX of the Social Security Act as amended and administered in Oregon.¶
(47) "These Rules" means the rules in OAR chapter 411, division 016.¶
(48) "Undue Influence" means the process by which an individual uses their role, relationship and/or power to exploit the trust, dependency, and fear of another individual, to deceptively gain control over that individual's

decision making, finances, home, property, medication, social interaction, or ability to communicate with others. Exertion of undue influence may exist whether a consumer-employer willfully allows another individual to assume decision-making control. When someone is exercising undue influence over or has something to personally gain from the consumer -- this constitutes a conflict of interest. ¶
(49) "Unpaid Caregiver" means a caregiver that meets the criteria in OAR 411-016-0130(1).
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0010

RULE SUMMARY: Establishes the responsibilities of Oregon Project Independence Services Case Managers and Fiscal Intermediaries, requires case management services be conflict-free and provides standard if provider organization provides both case management and direct services.

CHANGES TO RULE:

411-016-0010
Scope of OPI-M Services Case Management
(1) Services Case Managers are responsible for: ¶
(a) Person-centered service plan development including goals, preferences and plan monitoring;¶
(b) Presenting program options, service options, resources, and alternatives to an individual to assist the individual and their representative in making informed choices and decisions;¶
(c) Risk assessment and monitoring, including:¶
(A) Identifying and documenting risks; ¶
(B) Working with an individual to eliminate or reduce risks;¶
(C) Developing and implementing a Risk Mitigation Plan;¶
(D) Monitoring risks at least quarterly and more frequently if needed; and ¶
(E) Adjusting an individual's person-centered service plan as needed.¶
(d) Other program coordination such as helping an individual navigate or coordinate with other social, health, and assistance programs;¶
(e) Assisting with crisis response and intervention such as participating in problem resolution with an individual or the individual's representative;¶
(f) Authorizing services to meet the service choices, assessed need and preferences of the individual, considering natural supports and other alternative service resources and service plan related notifications;¶
(g) Service provision issues such as assisting an individual with problem solving to resolve providers, services or hours issues that do not meet the individual's needs; ¶
(h) Informing individuals of grievance and hearing rights and following grievance and hearing processes.¶
(i) Documentation of changes in condition, service plan adjustments and reasons for adjustments, service alternatives, completion of required forms and other service plan case management requirements including narration; and,¶
(j) Completing an Unpaid Caregiver assessment if Community Caregiver Supportive Services or Caregiver Education and Training is requested.¶
(2) Fiscal Intermediary Responsibilities: Services case managers are responsible for the following tasks if fiscal intermediary services are available:¶
(a) Enrolling the individual into fiscal intermediary services;¶
(b) Coordinating and reviewing benefit expenditures;¶
(c) Resolving payment issues with fiscal intermediary; and¶
(d) Problem solving and monitoring fiscal intermediary services defined in provider contracts.¶
(3) Case management services must meet the conflict-free case management expectations. When the only willing and qualified provider organization provides both case management and direct services, Department approved firewalls must be in place and followed to ensure a separation of functions within the organization. Conflict-free case management protects against conflicts of interest, fraud and misuse of funding to benefit a provider. ¶
(4) Type B transfer AAA staff serving as OPI-M Services Case Managers may also serve as Eligibility Case Managers.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0020

RULE SUMMARY: Establishes criteria for Oregon Project Independence-Medicaid Services Case Managers.

CHANGES TO RULE:

411-016-0020
Qualified Services Case Manager
Services Case Managers must meet the following criteria:¶
(1) Be employed by an Area Agency on Aging, the Department or a subcontractor of a Type B AAA transfer that was subcontracting to provide OPI case management prior to June 1, 2024.¶
(2) Have completed the Department required training for case managers; and¶
(3) The AAA or the Department has determined that the Services Case Manager has the skills, knowledge and ability for the Services Case Manager position and responsibilities.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0025

RULE SUMMARY: Provides responsibilities for individuals to receive Oregon Project Independence-Medicaid services. Allows ending of services if requirements are not met and gives criteria for re-instatement and permanent closure. Specifies monthly case manager contacts until end of OPI-M continuous eligibility period.

CHANGES TO RULE:

411-016-0025
OPI-M Service Eligibility and Responsibilities of the Individual
(1) For ongoing approval of an OPI-M service plan, the individual must receive case management services and the individual or their representative participate in the person-centered service planning process. ¶
(a) Individuals who do not have case management services or participate in the yearly person-centered service plan may have their OPI-M services end until the person-centered service plan is completed. ¶
(b) Individuals remain eligible for OPI-M until either the end of their continuous eligibility period or they voluntarily withdraw.¶
(2) Individuals must participate in risk assessments and risk monitoring activities as a part of case management and service coordination. If individuals do not participate in the risk assessment and risk monitoring activities the case manager will continue to contact the individual at least once per month until services are added to the plan, the individual voluntarily withdraws or the end of the continuous eligibility period.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0030

RULE SUMMARY: Describes person-centered planning process that Oregon Project Independence-Medicaid Services Case Managers must use with individuals enrolled in Oregon Project Independence-Medicaid to develop service plans. Lists services that OPI-M consumers may choose as part of their service plan. Describes elements of the plan that must be documented by the Services Case Manager and requirement that Services Case Manager monitor and adjust plans as needed and ensure the individuals' preferences are represented in the service plan. Includes that service planning must be conflict free, use program grievance process to try to resolve differences should grievances arise and gives time frames for service planning completion.

CHANGES TO RULE:

411-016-0030
Person-Centered Service Planning
(1) Services Case Managers must use a person-centered service planning process to develop person-centered service plans. The process must:¶
(a) Be directed by the individual and include people chosen by the individual;¶
(b) Occur at times and locations of convenience to the individual; ¶
(c) Provide necessary information and supports so that the individual can make informed choices and decisions;¶
(d) Offer all available service options including assistive devices, home modifications and other alternative service resources as defined in OAR 411-014-0005 to meet the identified needs;¶
(e) Include assessing the cost effectiveness and sustainability of the plan;¶
(f) Result in authorization of the minimum level of services that the individual chooses and is eligible for, that are required to adequately meet the individual's assessed needs or support the unpaid caregiver and caregiving relationship; ¶
(g) Be documented in Oregon Access, CA/PS and other approved forms and systems.¶
(h) Local offices should work with participants to resolve service disagreements through local processes and the OPI-M grievance process. In the event there is no local level resolution, OPI-M participants have contested case hearing rights as described in OAR chapter 461, division 025.¶
(i) The SCM must contact the eligible individual within 14 days of the eligibility determination and complete the service plan within 30 days.¶
(2) The individual or individual's representative is responsible for choosing and assisting in developing a cost-effective person-centered service plan. ¶
(a) The case manager must ensure the individual's preferences are represented in the plan and other involved parties do not exert undue influence. ¶
(b) There must be no conflicts of interest between the individual and others involved in the service planning process. ¶
(3) In developing the service plan, Services Case Managers must address the:¶
(a) Personal preferences and cultural considerations of the individual; and¶
(b) Health and welfare of the individual.¶
(4) The process must use the language, format, and presentation methods appropriate for effective communication according to the needs, preferences, and abilities of the individual, and if applicable, representative of the individual.¶
(5) Eligible OPI-M consumers may choose one or more of the following services for their OPI-M service plan, if the requirements of the service are met, available and the services are authorized by the Services Case Manager:¶
(a) Adult day services;¶
(b) Assisted and community transportation;¶
(c) Assistive technology;¶
(d) Caregiver education and training;¶
(e) Case management and service coordination;¶
(f) Chore services;¶
(g) Community Caregiver Supportive Services;¶
(h) Emergency response systems;¶
(i) Evidence-based health promotion services;¶
(j) Home delivered meals;¶
(k) Home modifications; ¶
(l) In-Home services from either:¶
(A) A Homecare worker employed in the Consumer-Employed Provider Program in OAR 411-016-0075; or ¶

(B) In-Home Care Agency;¶
(m) Long term care community nursing;¶
(n) Supports for Consumer Direction; and¶
(o) Special Medical Equipment.¶
(6) All services in the plan must be prior authorized by the Department or the Services Case Manager.¶
(7) The plan must include and document in CA/PS or Department approved forms the following:¶
(a) The goals, strengths and preferences of the individual, including but not limited to relationships, greater community participation, employment, healthcare and wellness, and education;¶
(b) The selected services and supports; ¶
(c) Providers of services and supports, including natural supports;¶
(d) Agreed upon contact frequency with the individual or representative, no less than quarterly; ¶
(e) Risk assessment, factors and measures agreed upon to minimize risk;¶
(f) The assignment of the fiscal intermediary, if available; and¶
(g) For individuals, receiving Community Caregiver Supportive Services and Caregiver Education and Training, the Unpaid Caregiver assessment. ¶
(8) The individual or their representative must sign the plan or may give verbal consent. Verbal consent must be documented in the case narrative. ¶
(9) The Services Case Manager must monitor and may adjust the person- centered service plan:¶
(a) At the request of the individual or representative of the individual;¶
(b) When the circumstances or needs of the individual change;¶
(c) After any service eligibility determination; or¶
(d) When other circumstances warrant change, including but not limited to provider availability or inability to meet client-employed provider requirements; or¶
(e) At least every 12 months.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0040

RULE SUMMARY: Provides standards for authorizing and paying in-home caregiver and in-home agency hours in service plans. Includes clause to allow respite hours.

CHANGES TO RULE:

411-016-0040
Service Plan Hours
(1) Through a person-centered planning process with the individual, the Services Case Manager authorizes hours to address the individual's unmet needs or to support the unpaid caregiver relationship.¶
(2) A service plan may have no more than a maximum total of 40 hours of in-home services including both ADL and IADL hours, per pay period.¶
(3) Hours are authorized to meet assessed ADL/IADL needs as defined in OAR 411-015-0006 and OAR 411-015-0007. ¶
(4) Hours should reflect only the minimum necessary for health and safety that supplement supports provided by natural supports and alternative service resources. The hours authorized must be documented in the service plan form.¶
(5) For households with two or more eligible individuals receiving any combination of Medicaid funded or Oregon Project Independence in-home services, the service plan for each individual must avoid duplication of services.¶
(6) Hours authorized for assessed needs are paid at the rates in accordance with OAR 411-027-0170 for In-Home Care Agencies and for Homecare Workers at rates published on the current rate schedule or the current collective bargaining agreement between the Department of Administrative Services on behalf of the State of Oregon and the Oregon Homecare Commission and Service Employees International Union, Local 503, Oregon Public Employees Union. ¶
(7) A provider may not receive payment from the Department for more than the total amount of in-home services hours authorized by the AAA or the Department on the service plan authorization form under any circumstances. All service payments must be prior authorized by a Services Case Manager or AAA or Department designated staff. ¶
(8) Payment by the Department for In-Home services hours are only made for the tasks described in OAR 411-015-0006 and OAR 411-015-0007 as ADL or IADL tasks. Services must be authorized to meet the needs of an eligible individual and may not be provided to benefit an entire household.¶
(9) Respite hours may be authorized to replace an unpaid caregiver or natural supports providing ADL or IADL care who are temporarily unavailable to provide assistance. Respite hours must be included in the 40 in-home services hours limit.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0050

RULE SUMMARY: Describes actions which the Oregon Department of Human Services may take to minimize consumer health and safety risks including declining to authorize service providers or services. Requires the Services Case Manager present alternatives to services that will not be authorized. Requires that the service plan payment is payment in full for OPI-M services and restricts Medicaid-paid providers from demanding or requiring additional payments for services from program participants for services in the OPI-M service plan.

CHANGES TO RULE:

411-016-0050
Limitations on In-Home Services Plans
(1) The AAA or Department must take necessary safeguards to protect an individual's health, safety, and welfare when implementing an individual's service plan in accordance with 42 CFR 441.302 and 42 CFR 441.570. When an individual with the ability to make an informed decision selects a service choice that jeopardizes health and safety, AAA or Department staff shall offer or recommend options to the individual to minimize those risks. For this rule, an "informed decision" means the individual understands the benefits, risks, and consequences of the service choice selected. Minimizing risks may include offering or recommending one or more of the following:¶
(a) Natural supports to help with safety or health emergencies;¶
(b) An emergency response system;¶
(c) A back-up plan for assistance with service needs;¶
(d) Resources for emergency disaster planning;¶
(e) A referral for long term care community nursing services;¶
(f) Resources for provider and consumer training;¶
(g) Assistive devices; or¶
(h) Home modifications.¶
(2) The Department or a AAA with the approval of the Department may decide not to authorize a service provider, a service or a combination of services selected by an eligible individual or the individual's representative when:¶
(a) There are dangerous conditions that jeopardize the health or safety of the individual and necessary safeguards cannot be taken to improve the situation;¶
(b) Services cannot be provided safely or adequately by the service provider based on:¶
(A) The extent of the individual's service needs; or¶
(B) The choices or preferences of the eligible individual or the individual's representative;¶
(c) Dangerous conditions jeopardize the health or safety of the service provider that is authorized and paid for by the Department, and necessary safeguards cannot be taken to minimize the dangers; or¶
(d) The individual does not have the ability to make an informed decision, does not have a representative to make decisions on their behalf, and the AAA or Department cannot take necessary safeguards to protect the safety, health, and welfare of the individual.¶
(3) The services case manager must present the individual or the individual's representative with information on service alternatives and provide assistance to assess other choices when the service provider or service setting selected by the individual or the individual's representative is not authorized. The Services Case Manager must document in the case file the service alternatives offered.¶
(4) The service plan payment is payment in full for the Oregon Project Independence-Medicaid services. Under no circumstances, may any Medicaid-paid provider demand or receive additional payment from an eligible individual, or other entity on behalf of the individual, for any services in the OPI-M service plan.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0075

RULE SUMMARY: Describes employer requirements for consumers to receive in-home services from a client-employed homecare worker. Allows Department to require and approve a consumer chosen representative if consumer is unable to meet employer requirements. Lists circumstances under which the Department may deny a request for a representative and requires consumers with guardians to use their guardian as their representative. Disallows paid caregivers from being consumer representatives for the consumers they work for.

CHANGES TO RULE:

411-016-0075
Consumer-Employer Responsibilities
(1) CONSUMER-EMPLOYER RESPONSIBILITIES. To be eligible for OPI-M in-home services provided by a homecare worker, an individual or the individual's representative must be able to:¶
(a) Locate, screen, and hire a qualified homecare worker;¶
(b) Supervise and train the homecare worker;¶
(c) Schedule the homecare worker's work, leave, and coverage;¶
(d) Track the hours worked and verify the authorized hours completed by the homecare worker;¶
(e) Recognize, discuss, and attempt to correct any performance deficiencies with the homecare worker;¶
(f) Discharge an unsatisfactory homecare worker; and¶
(g) Follow all employer responsibilities required by law to ensure the workplace is safe from harassment.¶
(2) The Department may require individuals who have failed to meet the responsibilities in section (1) of this rule to designate a representative to exercise these responsibilities. A representative of an individual may not be a homecare worker providing In-Home services to the individual.¶
(a) Individuals who have failed to meet the responsibilities in section (1) of this rule and who do not have a representative are ineligible for in-home services provided by a homecare worker.¶
(b) Individuals must also be offered other available OPI-M service options to meet the individual's service needs.¶
(3) An individual determined ineligible for in-home services provided by a homecare worker and who does not have a representative may request in-home services provided by a homecare worker at the individual's next re-assessment, but no sooner than 12 months from the date the individual was determined ineligible.¶
(a) To reestablish eligibility for in-home services provided by a homecare worker, an individual must attend training and acquire, or otherwise demonstrate, the ability to meet the employer responsibilities in section (1) of this rule. Improvements in health and cognitive functioning, for example, may be factors in demonstrating the individual's ability to meet the employer responsibilities in section (1) of this rule.¶
(b) If the Department determines an individual may not meet the individual's employer responsibilities, the Department may require the individual to appoint an acceptable representative.¶
(4) The Department retains the right to approve the representative selected by an individual. Approval may be based on, but is not limited to, the representative's criminal history, protective services history, or credible allegations of fraud or collusion in fraudulent activities involving a public assistance program.¶
(5) If an individual's representative is unable to meet the employer responsibilities of section (1) of this rule, or the Department does not approve the representative, the individual must designate a different representative or select other available services.¶
(6) An individual with a history of credible allegations of fraud or collusion in fraud with respect to in-home services is not eligible for in-home services provided by a homecare worker.¶
(7) REPRESENTATIVE.¶
(a) The Department may require that an individual obtain a representative to act as the consumer-employer or for service planning purposes.¶
(b) The Department, or the Department's designee, may deny an individual's request for any representative if the representative has a history of a substantiated adult protective service complaint as described in OAR chapter 411, division 020. The individual may select another representative.¶
(c) An individual with a guardian must have a representative to act as the consumer-employer and for service planning purposes. A guardian may designate themselves as the representative.¶
(d) A representative may not be a paid caregiver for the individual they are representing.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0080

RULE SUMMARY: Requires paid caregivers to be homecare workers enrolled in the Consumer-Employed Provider program. Sets homecare workers hours limits within OPI-M.

CHANGES TO RULE:

411-016-0080
Homecare Workers and Provider Qualifications
(1) For the purpose of this rule, case manager as used in OAR chapter 411, division 031 means the OPI-M Services Case Manager.¶
(2) Homecare workers must be enrolled in and follow the rules in the Consumer-Employed Provider Program described in chapter 411, division 031 to provide in-home services as part of an OPI-M service plan. ¶
(3) A single homecare worker is limited to providing 16 hours of awake care during a 24-hour work period.¶
(4) All homecare workers are limited to no more than 60 hours per week. ¶
(5) Homecare workers must use Electronic Visit Verification (EVV) as required in OAR 411-031-0040(10)(a).
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0090

RULE SUMMARY: Requires In-Home Care Agencies providing OPI-M services to meet In-Home agency standards, provider enrollment requirements and payment standards in Oregon Administrative Rule chapter 411, division 033.

CHANGES TO RULE:

411-016-0090
In-Home Agency Services and Provider Enrollment
(1) For the purpose of this rule, ¶
(a) Case manager as used in OAR 411-033-0020 is synonymous with the Services Case Manager in OAR 411-014-0010; and¶
(b) Individual as used in OAR 411-033-0020 is modified to apply to people aged 60 or older or an adult aged 18 or older with physical disability.¶
(2) In-Home Care Agency Services authorized as part of an OPI-M service plan must comply with OAR 411-033-0020 and with provider enrollment requirements and payment in OAR 411-033-0030.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0100

RULE SUMMARY: Allows the authorization of Adult Day Services as part of an OPI-M service plan. Sets standards and registration requirements for Adult Day Services providers. Requires ADS providers to have a Medicaid provider number.

CHANGES TO RULE:

411-016-0100
Adult Day Services (ADS) and ADS Provider Qualifications
(1) An eligible individual may choose to receive services, in lieu of hours, from an ADS.¶
(2) If chosen by the eligible individual, the OPI-M Services Case Manager authorizes and monitors ADS services in an OPI-M service plan. The amount of time authorized for ADS should be used to reduce the number of hours authorized from the maximum in-home hours.¶
(3) Adult Day Services programs must adhere to the standards in OAR 411-066-0020, registration requirements in OAR 411-066-0010 and be certified and maintain a Medicaid provider number as in OAR 411-066-0015.¶
(4) Adult Day Services will be paid in accordance with OAR 411-027-0020(6).
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0110

RULE SUMMARY: Allows authorization of Assistive Technology and Emergency Response Systems (ERS) in OPI-M service plans. Requires Assistive Technology and ERS to meet standards and provide services in compliance with Oregon Administrative Rule chapter 411, division 035. Requires Oregon Department of Human Services, Aging and People with Disabilities Program approval for requests over $500.

CHANGES TO RULE:

411-016-0110
Assistive Technology, Emergency Response Systems and Provider Qualifications
(1) Assistive Technology such as electronic back-up systems and Emergency Response systems may be authorized in an OPI-M service plan by an OPI-M Services Case Manager for individuals who meet the criteria in OAR 411-035-0025.¶
(2) Assistive Technology and Emergency Response systems must meet the criteria in OAR 411-035-0030.¶
(3) Assistive Technology and Emergency Response System providers must meet the requirements of and provide services in compliance with OAR 411-035-0035.¶
(4) All requests over $500 must be approved by designated Department Central Office staff.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0120

RULE SUMMARY: Provides standards for assisted and community transportation benefit, who may be a qualified provider, what type of transportation can be provided under the benefit, requires prior authorization and addresses reimbursements. Allows prior authorization of community transportation to support community integration goals in the service plan. Sets a maximum for community integration rides of 100 miles if provided by a homecare worker or 8 rides if provided by a contracted transportation provider, per pay period. Includes clause that the Department is not liable for claims when provider is using a personal motor vehicle.

CHANGES TO RULE:

411-016-0120
Assisted and Community Transportation and Provider Qualifications
(1) Assisted transportation is offered through homecare workers or in-home care agencies who have a valid Medicaid provider number. Hours authorized for assisted transportation are included in the 40-hour maximum per pay period.¶
(2) Assisted transportation may be provided during medically related transportation if related to an ADL or IADL needs and part of the prior authorized service plan.¶
(3) Community transportation is offered through contracted transportation providers, public transportation, homecare workers or in-home care agencies who have a valid Medicaid provider number.¶
(4) Community transportation (non-medical) may be prior authorized for reasons related to an eligible individual's ADL and IADL needs and safety or health, in accordance with the individual's service plan. Community transportation may also be prior authorized to support the individual's well-being and for access to community-based services, activities, and resources if community integration is a goal in the individual's person-centered service plan. ¶
(5) A maximum of 100 miles per pay period may be authorized for rides provided by homecare workers or in-home care agencies or 8 rides per pay period if provided by a contracted transportation provider may be authorized for transportation related to community-based services, activities, and resources.¶
(6) When available to an eligible individual, natural supports, volunteer transportation, and other transportation services are considered a prior resource and may not be replaced with transportation paid for by the Department. Unmet transportation needs may be part of an OPI-M Service plan.¶
(7) Medical transportation costs are not reimbursed through community transportation. Community transportation is not provided by the Department to obtain medical or non-medical items that may be delivered by a supplier or sent by mail order without extra cost to the eligible individual.¶
(8) Community transportation must be prior authorized by an individual's Services Case Manager and documented in the individual's service plan. The Department does not pay any provider under any circumstances for more than the total number of hours, miles, or rides prior authorized by the Department or AAA and as documented in the individual's service plan.¶
(a) Contracted transportation providers are reimbursed according to the terms of their contract with the Department. Community transportation services provided through contracted transportation providers must be prior authorized by a Services Case Manager based on an estimate of a total count of one-way rides per month.¶
(b) Homecare workers who use their own personal vehicle for community transportation are reimbursed according to the terms defined in their Collective Bargaining Agreement between the Home Care Commission and Service Employees International Union, Local 503, OPEU. Any mileage reimbursement must be prior authorized to a homecare worker and must be based on an estimate of the maximum miles required to drive to and from the destination authorized in an individual's service plan. ¶
(c) The AAA may not authorize reimbursement for travel to or from the residence of a homecare worker. The AAA only authorizes community transportation and mileage from the home of an eligible individual to the destination authorized in the individual's service plan and back to the individual's home.¶
(9) The Department is not responsible for any vehicle damage or personal injury sustained or other liability incurred while using a personal motor vehicle for community transportation.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0130

RULE SUMMARY: Defines unpaid caregiver-based longevity of caregiving, condition of eligible individual, caregiving hours, caregiving needs, skills. Lists topics of education and training that may be authorized. Allows authorization of the service for unpaid providers that have the ability to learn to perform caregiving tasks. Describes prior authorization process, provider qualifications and excluded payment for training readily available for free elsewhere.

CHANGES TO RULE:

411-016-0130
Unpaid Caregiver Education and Training and Provider Qualifications
(1) For the purposes of this rule, an unpaid caregiver means a person providing assistance that meets the following conditions:¶
(a) Longevity/Acuity:¶
(A) The caregiver has been providing unpaid caregiving for 3 months or longer; and¶
(B) Expects to continue providing caregiving for 3 months or longer; or¶
(C) The individual is receiving hospice services; or¶
(D) There is a new diagnosis of an acute or traumatic event causing an increase in the need for activities of daily living care and the increase in additional care is expected to last 3 months or longer; or¶
(E) There is a significant deterioration of functional ability causing the need for an immediate increase in assistance with activities of daily living which is expected to last 3 months or longer.¶
(b) The eligible individual, or their representative, attests that the unpaid caregiver meets the longevity and other criteria of this rule.¶
(c) The unpaid caregiver provides in person care in the individual's home or community at least 10 hours per week.¶
(d) The unpaid caregiver is providing Activities of Daily Living or Instrumental Activities of Daily Living care or assistance with treatments related to the individual's needs that are identified in the CA/PS assessment or Department approved forms.¶
(e) The unpaid caregiver has the skills, knowledge and ability to adequately or safely perform or learn to perform the required work. This means the unpaid caregiver possesses and demonstrates the physical, mental, organizational, and emotional skills or abilities necessary to perform or learn to perform services which safely and adequately meet the needs of the individual.¶
(2) Caregiver Education and Training may be authorized to improve an unpaid caregiver's skills, knowledge, ability to perform caregiving tasks that support health and safety of eligible individuals or to help the unpaid caregiver manage the stress of caregiving.¶
(3) Caregiver Education and Training may be authorized for, but is not limited to, the following topics:¶
(a) Chronic disease self-management;¶
(b) Dementia; ¶
(c) Fall prevention;¶
(d) Depression;¶
(e) Self-care;¶
(f) Stress Reduction; ¶
(g) Suicide prevention;¶
(h) Addressing complex behaviors;¶
(i) Loneliness and isolation;¶
(j) Hoarding; and ¶
(k) Culturally specific caregiving.¶
(4) Through a person-centered planning process with the individual, the Services Case Manager must assess and document the request for caregiver education on the service plan form using the Unpaid Caregiver Assessment tool. ¶
(5) The eligible individual or the representative may request topic specific caregiver education and training and the request shall be documented in the service plan. If the unpaid caregiver requests education and training, the SCM will work with the individual to determine if the service will be included in the service plan. ¶
(6) Unpaid caregivers are not paid for their time attending caregiver education and training or for their transportation to and from training. Unpaid caregivers will not be charged training tuition or registration fees.¶
(7) Caregiver Education and Training providers are contracted entities that provide one to one training or those that are contracted to provide classroom type trainings or online if the content does not require hands-on learning. Providers may be reimbursed for reasonable costs for transportation for participants attending training.¶

(8) Caregiver Education and Training does not count in the hourly maximum hours.¶
(9) Caregiver Education and Training providers must at a minimum meet the following requirements:¶
(a) Be over the age 18;¶
(b) Have a high school diploma or GED;¶
(c) Pass a department approved background check as described in OAR chapter 407, division 7;¶
(d) Have demonstrated experience in assisting caregivers of older adults and people with disabilities;¶
(e) Are subject matter experts with demonstrated experience in their field;¶
(f) Meet the training, licensing or credential requirements for the education and training they are providing; and¶
(g) Meet the qualifications to be a Medicaid enrolled provider and be enrolled as a Medicaid provider.¶
(10) Caregiver Education and Training may not be authorized for education and training available through Long Term Care Community Nursing.¶
(11) Caregiver Education and Training may not be authorized for In-Home Care Agency providers.¶
(12) Caregiver Education and Training may not be authorized in place of readily available free training accessible to unpaid caregivers unless the quality of the education and training is more substantive or relevant than the free training.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0140

RULE SUMMARY: Defines who is eligible for chore services, the purpose of chore services and provider qualifications and requirements. Excludes chore services from cap on the maximum number of hours per pay period.

CHANGES TO RULE:

411-016-0140
Chore Services and Provider Qualifications
(1) Chore services assist individuals to maintain their health and safety and are beyond the scope of ADL and IADL tasks as defined in OAR 411-015-0006 and OAR 411-015-0007.¶
(2) To be eligible for chore services, an individual must meet the criteria in OAR 411-035-0040.¶
(3) Chore services must meet the eligible chore service criteria in OAR 411-035-0045. ¶
(4) Chore services are not subject to the 40-hour cap.¶
(5) Chore services providers must meet the qualifications and follow the requirements in OAR 411-035-0050.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0150

RULE SUMMARY: Allows authorization of the benefit as part of the service plan. Requires the use of the Unpaid Caregiver Assessment tool to document need for the benefit. Provide examples of services under the benefit, defines provider qualifications and provider payment process.

CHANGES TO RULE:

411-016-0150
Community Caregiver Supportive Services and Provider Qualifications
(1) Community Caregiver Supportive Service may be authorized to assist the individual and their natural support systems. ¶
(2) Through a person-centered planning process with the individual, the Services Case Manager must assess and document the need for Community Caregiver Supportive Services on the service plan form using the Unpaid Caregiver Assessment tool.¶
(3) The caregiver meets the criteria for an unpaid caregiver in OAR 411-016-0130(1).¶
(4) Services include but are not limited to:¶
(a) Paid wellness services;¶
(b) Group-based activities;¶
(c) Peer supports; and¶
(d) Facilitated support groups.¶
(5) Community Caregiver Supportive Services providers must at a minimum meet the following requirements:¶
(a) Be over age 18;¶
(b) Have a high school diploma or GED;¶
(c) Pass a department approved background check;¶
(d) Have demonstrated experience in assisting caregivers of older adults and people with disabilities;¶
(e) Are subject matter experts with demonstrated experience in their field; ¶
(f) Meet the training, licensing or credential requirements for the supportive service they are providing; and¶
(g) Meet the qualifications to be a Medicaid enrolled provider and be enrolled as a Medicaid provider.¶
(6) Services must be prior authorized by the Services Case Manager.¶
(7) Providers are paid depending on the service by one of the following processes as directed by the Department:¶
(a) Provider submits competitive rate bid for approval to the case manager; or¶
(b) Invoice is submitted at the contracted rate. ¶
(8) No payment will be released to the provider until the work is finished and meets the specifications of the service.
Statutory/Other Authority: ORS 410.020, 410.070
Statutes/Other Implemented: ORS 410.020, 410.070

ADOPT: 411-016-0160

RULE SUMMARY: Defines services authorized under the benefit, service requirements, provider qualifications, provider payment process and mandates service provider must follow conflict-free case management expectations.

CHANGES TO RULE:

411-016-0160
Evidence Based Health Promotion Services and Provider Qualifications
(1) Evidence Based Health Promotion Services assist eligible individuals to maintain or improve their health or build skills to manage health conditions. These services include, but are not limited to: ¶
(a) Program to Encourage Active, Rewarding Lives for Seniors (PEARLS);¶
(b) Healthy IDEAS (Identifying Depression Empowering Activities for Seniors);¶
(c)The suite of Chronic Disease Self-Management Education (CDSME) programs;¶
(d) Fit & Strong!;¶
(e) A Matter of Balance; ¶
(f) The Otago Exercise Program (OEP);¶
(g) Tai Chi - Moving for Better Balance; and¶
(h) SHARE for Dementia (Support, Health, Activities, Resources, Education).¶
(2) Evidence Based Health Promotion Services must:¶
(a) Demonstrate through evaluation that they are effective for improving the health and well-being or reducing disease, disability and/or injury among older adults or younger people with disabilities; ¶
(b) Been proven effective with older adult population or younger people with disabilities, using designs with or without random assignment and a control group;¶
(c) Have research results published in a peer-review journal;¶
(d) Have been carried out in one or more community site(s) identical to the program that was evaluated to be effective in the published research and shown to be effective; and¶
(e) Include developed dissemination products that are available to the public.¶
(3) Providers must at a minimum meet the following requirements: ¶
(a) Be over the age 18; ¶
(b) Have a high school diploma or GED;¶
(c) Pass a criminal background check as described in OAR chapter 407, division 007;¶
(d) Have demonstrated experience in assisting caregivers of older adults and people with disabilities;¶
(e) Are subject matter experts with demonstrated experience in their field;¶
(f) Meet the training, licensing or credential requirements for the service they are providing: ¶
(g) Meet the qualifications to be a Medicaid enrolled provider and be an enrolled as a Medicaid provider; and¶
(h) Ensure and deliver the program meets the requirements to be Evidence-Based as described in section (2).¶
(4) Evidence Based Health Promotion services may not be authorized if they duplicate services available through Long Term Community Nursing, Older Americans Act programs and Services or other available resources.¶
(5) Evidence Based Health Promotion Services must meet the conflict-free case management expectations. When the only willing and qualified provider organization provides both case management and Evidence Based Health Promotion Services, Department approved firewalls must be in place and followed to ensure a separation of functions within the organization. ¶
(6) Evidence Based Health Promotion services are not included in the 40-hour maximum hours.¶
(7) Payments. ¶
(a) Providers may not charge OPI-M individuals for participation.¶
(b) Rates for OPI-M must be no more than those charged for private pay individuals, Older Americans Act Programs and constitute payment in full for services rendered.¶
(c) Services must be prior authorized by the Services Case Manager.¶
(d) Payment will be made by the Department after services have been provided and invoices have been submitted and approved by the Services Case Manager or Department representative.
Statutory/Other Authority: Section 361 of the Older Americans Act (OAA) of 1965, as amended, ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0170

RULE SUMMARY: Defines who is eligible for home delivered meals, provider qualifications and payment standards, limits and processes, meal requirements, mandates service provider must follow conflict-free case management expectations.

CHANGES TO RULE:

411-016-0170
Home Delivered Meals and Provider Qualifications
(1) To be eligible for home delivered meals a participant must:¶
(a) Be eligible for OPI-M;¶
(b) Be unable to complete meal preparation as defined in OAR 411-015-0007 on a regular basis without assistance; and¶
(c) Not have natural supports available that are willing and able to provide meal preparation services.¶
(2) Home Delivered Meals must meet the conflict-free case management expectations. When the only willing and qualified provider organization provides both case management and Home Delivered Meals, Department approved firewalls must be in place and followed to ensure a separation of functions within the organization. ¶
(3) Services Case Managers must perform all the functions of case managers authorizing Medicaid home delivered meals as described in OAR 411-040-0050. ¶
(4) If a participant is determined ineligible for Medicaid home delivered meals, but needs food assistance, the Services Case Manager shall refer the participant to the nearest Aging and Disability Resource Connection for assistance.¶
(5) OPI-M Home Delivered Meals providers must meet:¶
(a) The qualifications and responsibilities for Medicaid paid Home Delivered Meal providers in OAR 411-040-0030; and ¶
(b) The service requirements in OAR 411-040-0036, and¶
(c) The staff and volunteer requirements in OAR 411-040-0037.¶
(6) OPI-M paid meals must meet the requirements in OAR 411-040-0035.¶
(7) The payment rate for Home Delivered Meals is documented in OAR 411-027-0170.¶
(8) Home Delivered Meals must be prior authorized by the Services Case Manager.¶
(9) Providers may be paid for no more than two meals per day per participant within the month. This service does not constitute the full nutritional regiment.¶
(10) OPI-M home delivered meals may be authorized in combination with other in-home services if meals are an appropriate resource to meet an identified need.¶
(11) If OPI-M home delivered meals are authorized, the service plan should be updated to address any duplicative meal preparation services.
Statutory/Other Authority: ORS 410.070, 411.070
Statutes/Other Implemented: ORS 410.060, 410.070, 410.240, 410.250, 410.270, 410.280, 414.065

ADOPT: 411-016-0180

RULE SUMMARY: Defines who is eligible for the benefit, service standards, provider qualifications and payment requirements and processes.

CHANGES TO RULE:

411-016-0180
Home Modifications and Provider Qualifications
(1) Home modifications may be authorized for OPI-M eligible individuals whose circumstances meet the consumer environmental modifications criteria in OAR 411-035-0055.¶
(2) Home modifications must be eligible environmental modifications described in OAR 411-035-0060.¶
(a) An individual or the individual's representative may request home modifications listed in OAR 411-035-0060 if needed to assist with the performance of an ADL or IADL, for the health and safety of the individual or to reduce the need for the assistance of a paid caregiver. ¶
(b) An individual or the individual's representative must make requests to the Services Case Manager and provide any requested documentation of the unmet needs that will be addressed by the modification.¶
(c) The Department will make all decisions on home modification exception requests. ¶
(3) Home modification providers must meet the environmental modifications provider qualifications and requirements in OAR 411-035-0065.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0190

RULE SUMMARY: Requires health-related needs for eligibility for Community Nursing services, prohibits duplication of nursing services paid by other sources, defines nursing benefit including limitations, provider qualifications and practices, payment rates and processes.

CHANGES TO RULE:

411-016-0190
Long Term Care Community Nursing Services and Provider Qualifications
(1) Individuals with health-related needs as assessed by the Services Case Manager are eligible for long term care community nursing services as described in Oregon Administrative Rule chapter 411, division 048.¶
(2) For the purposes of these rules, the term case manager used in chapter 411, division 048 is synonymous with the term Services Case Manager used in these rules. ¶
(3) Long Term Care Community Nursing Services must be prior authorized by the Services Case Manager.¶
(4) Limitations:¶
(a) Services Case managers may not prior authorize long term care community nursing services that duplicate nursing services provided by Medicare or other Medicaid programs for which the individual is eligible.¶
(b) Long term care community nursing services do not include:¶
(A) Nursing activities used for other 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 (Definitions).¶
(B) Reimbursement for direct hands-on nursing as defined in OAR 411-048-0160 (Definitions).¶
(5) An exception to section (3)(b) of this rule may be requested as described in OAR 411-048-0250 (Exceptions).¶
(6) Long Term Care Community Nursing Services providers must:¶
(a) Provide the services and use the practices and procedures described in OAR 411-048-0180; and¶
(b) Follow the Communication and Notification Practices in OAR 411-048-0190; and¶
(c) Comply with the Additional Documentation requirements in OAR 411-048-0200; and¶
(d) Meet the provider qualifications in OAR 411-048-0210; and¶
(e) Meet orientation requirements in OAR 411-048-0240.¶
(7) All billing and claims must comply with:¶
(a) OAR 407-120-0330 (Billing Procedures) and 407-120-0340 (Claim and PHP Encounter Submission); and¶
(b) OAR chapter 410, division 120 as applicable; and¶
(c) The Long Term Care Community Nursing Procedure Codes and Payment Authorization Guidelines posted at https://www.oregon.gov/odhs/providers-partners/ltccn/Pages/resources.aspx#billing¶
(8) Compensation for long term care community nursing services shall be defined in the Department's rate schedule in OAR 411-027-0170 or through a contract with the Department. The Department may adjust rates in underserved areas to assure that individuals have access to long term care community nursing services.¶
(9) The Department may grant exceptions as described in OAR 411-048-0250 to Long Term Care Community Nursing Services for OPI-M participants.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 414.065

ADOPT: 411-016-0200

RULE SUMMARY: Defines special medical equipment and supplies, benefit eligibility, requires prior authorization, multiple bids, payment requirements and delivery requirements.

CHANGES TO RULE:

411-016-0200
Special Medical Equipment and Supplies
(1) Individuals may be eligible for specialized or durable medical equipment and medical supplies if no other payer such as Medicare, Medicaid medical benefits or other insurance is paying for the equipment or supplies.¶
(2) Special medical equipment or supplies must be necessary to support the consumer's health or well-being. Special medical equipment is not assistive technology as defined in OAR 411-016-0005 and is not a replacement or substitute for caregiver or unpaid caregiver services.¶
(3) Special medical equipment or supplies must be prior authorized in accordance with OAR 411-035-0015(2-6). ¶
(4) To be considered an eligible request, when possible, three bids are required from providers. Consumers should work with their Services Case Manager to obtain bids. Bids may not include comparative pricing done through the internet.¶
(5) Special medical equipment or supplies must be approved by Central Office. ¶
(6) No monetary funds shall be released for installation of special medical equipment or supplies to the provider until the work is finished and is functioning as expected.¶
(7) Upon delivery, providers must ensure:¶
(a) The product is functioning correctly;¶
(b) The product properly fits the consumer; and¶
(c) If applicable, the individual is given adequate instruction on the product's use.¶
(8) Providers must supply a revised bid when requested by designated Central Office staff.¶
(9) Providers must submit the final invoice for payment within one year of the date of service.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.020, 410.070

ADOPT: 411-016-0210

RULE SUMMARY: Defines support for consumer direction as advocacy training and skill building for employer role, health, safety, personal and life goals and self-advocacy for services and resources. Includes provider requirements and qualifications and payments.

CHANGES TO RULE:

411-016-0210
Supports for Consumer Direction
(1) Supports for Consumer Direction directly benefit the individual by providing skills and knowledge to become an effective employer of homecare workers, self-advocate for other services and resources and manage service plans and goals. This includes but is not limited to skill-building for self-advocacy, setting boundaries, identifying and achieving service plan and personal goals and life experiences that ensure health, safety and well-being, rights and responsibilities as an employer, creating a work schedule, supervising providers in the home, and how to address unsatisfactory work. ¶
(2) Supports for Consumer Direction may not duplicate other services or be authorized if available from other less expensive resources unless the quality of the education and training is more substantive or relevant than the other resources. ¶
(3) Providers must at a minimum meet the following requirements:¶
(a) Be an organization or individual with at least 2 years of experience in:¶
(A) Assisting older adults and people with disabilities to learn how to self-direct caregivers, or¶
(B) Educating older adults and people with disabilities to learn skills to be a self-advocate, or¶
(C) Educating older adults and people with disabilities to learn skills related to supported decision making.¶
(b) Be over the age 18;¶
(c) Have a high school diploma or GED;¶
(d) All staff have passed a criminal background check; and¶
(e) Be an enrolled Medicaid provider.¶
(4) Payments.¶
(a) Providers may not charge OPI-M individuals for participation.¶
(b) Rates for OPI-M must be comparable to those included in Department contracts or rates for similar services. ¶
(c) Payment must constitute payment in full for services rendered. ¶
(d) Payment will be made by the Department after services have been provided and invoices have been submitted and approved by the Services Case Manager or Department representative.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.065, 410.070

ADOPT: 411-016-0300

RULE SUMMARY: Covers AAA requirements regarding case management, data collection, record keeping and reporting. Includes the group of people that AAAs may case manage, requirements to collect and maintain OPI-M records and data on Department approved tools. Requires AAA maintenance of records and accounts including costs for at least seven (7) years and to provide Department access upon request. Includes fiscal and program reporting requirements and requires consumer confidentiality unless for a stated purpose and with the written consent of the consumer or consumer representative. Requires AAA to respond to communication and referrals for services from APD, eligible individuals and their representatives within five business days.

CHANGES TO RULE:

411-016-0300
AAA Case Management, Data Collection, Records, and Reporting
(1) CASE MANAGEMENT. ¶
(a) Type A and Type B contract AAAs will provide services case management to OPI-M cases without full Medicaid medical benefits.¶
(b) The Department may make exceptions to subsection (a) if the individual has an ongoing relationship with the AAA.¶
(c) Type A and Type B contract AAAs may provide services case management to individuals receiving Medicare Savings Programs.¶
(d) The Department's local office or the Type B transfer AAA will provide case management services to individuals eligible for full Medicaid medical benefits.¶
(2) DATA COLLECTION.¶
(a) The collection of required program and fiscal records and data associated with OPI-M must be on forms and data systems as approved by the Department.¶
(b) Each AAA and service provider must collect and maintain required data on eligible individuals receiving authorized services as required by the Department, including required Race, Ethnicity, Language and Disability (REALD) and Sexual Orientation and Gender Identity/Expression (SOGIE) data when Oregon ACCESS or other state data systems can include the data.¶
(c) All authorized service data collected on eligible individuals, supported by OPI-M must contain the individual's Social Security Number and date of birth.¶
(3) RECORDS.¶
(a) Each AAA must maintain all records, documents, and accounting procedures that reflect all administrative costs, program support costs, direct service costs, and service case management costs expended on OPI-M. These records must be retained for not less than seven years.¶
(b) Each AAA must make these records available upon request to the Department or to those duly authorized by the Department.¶
(4) FISCAL AND PROGRAM REPORTING:¶
(a) Fiscal and program reports must be completed on forms provided by the Department.¶
(b) Fiscal and program reports must be submitted to the Department by the specified due dates.¶
(c) Fiscal and program reports must, at a minimum, include:¶
(A) Current cumulative expenditures;¶
(B) Administrative costs;¶
(C) Program support costs;¶
(D) Services case management costs; and¶
(E) Demographic, social, medical, physical, functional, and financial data as required by the Department in the Department's Client Assessment/Planning System (CA/PS) and in the Oregon ACCESS database.¶
(5) CONFIDENTIALITY. The use or disclosure by any party of any information concerning a recipient of authorized services described in these rules, for any purpose not directly connected with the administration of the responsibilities of the Department, AAA, or service provider is prohibited except with written consent of the recipient, or the individual's representative. Disclosure of recipient information must meet Department requirements.¶
(6) COMMUNICATION. The AAA must respond to communication and OPI-M referrals for services from APD within five business days. Responses to communication from eligible individuals and their representatives must also occur within five business days. ¶
(7) OTHER INFORMATION. AAAs will provide other information required under the OPI-M and 1115 Demonstration Waiver, including the Special Terms and Conditions, approved by the Centers for Medicare &

Medicaid Services or by Department policy on OPI-M waiver administration.
Statutory/Other Authority: ORS 410.070
Statutes/Other Implemented: ORS 410.060, 410.070, 410.480, 414.065