IN-HOME SERVICES OVERVIEW

Updated 01/28/2022

Definition:
In-home services, refers to those services, provided at regularly scheduled times, which meet an individual's assessed needs related to Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). In-home services are intended to maximize an individual's independence and dignity through person-centered, flexible, and suitable services, and to supplement his/her personal abilities to continue living in his/her home.

Eligibility for In-Home Services:
An individual must . . .

- Be eligible for Medicaid benefits.
- Meet Medicaid Service Priority Level (SPL) eligibility criteria of 1-13, as determined by a functional needs assessment completed in the Client Assessment Planning System (CA/PS) (OAR 411-015-0010; OAR 411-015-0015). Medicaid service eligibility is based on age and functional impairment level (physical and cognitive limitations), within the SPLs.

Medicaid In-Home Programs:
Medicaid hourly in-home services are provided through:

1. The Consumer-Employed Provider (CEP) Program;
2. The Spousal Pay Program (SP); and
3. The Independent Choices Program (ICP)

In-Home Service Providers:
Providers of in-home services include:

1. Enrolled Homecare Workers (HCWs) in the CEP program, including those approved through the SP and the State Plan Personal Care (SPPC) programs.
2. In-Home Care Agencies (IHCA) which have contracts with APD.
3. Personal Support Workers (PSWs) in the ICP.

Scope of In-Home Services:

- ADL/IADL care needs are indicated on a consumer's person-centered service plan and reflected on the provider's task list.
- Waivered Case Management (WCM) services, also known as direct and indirect contacts, must be provided to any OSIPM-eligible consumer who receives services under the K State Plan Waiver. This excludes MAGI (unless they have been identified as having a high risk in the Risk Assessment) and OPI recipients and consumers who receive their services in a Nursing Facility (NF) or through Program of All-inclusive Care for the Elderly (PACE).
- Other available services include Medicaid Home Delivered Meals (HDMs), Adult Day Services (ADS), K-State Plan Ancillary Services, Emergency Response Systems (ERS), Behavioral Support Services (BSS) and Long-Term Care Community Nursing (LTCCN) services.

Applied Rules:

- Service Priorities: OAR 411-015-0000 through 411-015-0100

- Payment Limitation Rules: OAR 411-027-0005 through 411-027-0027
- In-Home Services (CEP): OAR 411-030-0001 through 411-030-0100
- HCWs: OAR 411-031-0020 through 411-031-0050
- In-Home Care Agency (IHCAs): OAR 411-033-0000 through 411-033-0030
- WCM Services: OAR 411-028-0000 through 411-028-0050

In-Home Exceptions:
Consumers may request an exception (a variance to APD service limits) based on an individual's documented service needs for:

- Maximum hours (OAR 411-027-0050 and OAR 411-030-0071)
- Shift services' hours over 16 hours per day (OAR 411-027-0050 & OAR 411-030-0068)
- The 40- and 50-hourly cap (OAR 411-027-0050 and OAR 411-030-0070(1))

Note: The APD 0514i form is used to request In-Home Exceptions, Shift Services and temporary HCW hourly cap exceptions.

Case Managers (CMs) who determine a need for exception hours, an exception to the hourly cap, or shift services:

- Are required to initiate the request and assist consumers by completing the APD 514i. Requests must be reviewed and have consent (verbally or in writing) from the consumer prior to submission. The CM also must discuss alternate ways, resources, and service options, if any, to meet the individual's needs consistent with the individual's right to independence, choice, and responsibility to assist in developing the less costly plan as described in OAR 411-030- 0050(2)(a) and *thoroughly narrate* this discussion.
- Local managers, supervisors, and/or Lead Workers must review all exception requests requiring Tier 3 review and approval. Central Office (CO) reserves the right to review any renewal for appropriateness, which includes Tier 2 approvals.
- When requesting an exceptional payment on the 514i, for an individual on the ICP, follow the In-Home Exceptions process and submit the SDS 0546IC2Wk form to the ICP email address at SPD.ICP@dhsoha.state.or.us.
- Exceptions which are granted or denied at the Department's discretion.

In-Home Consumer Representatives:
A "Representative" is an individual appointed by a consumer to participate in service planning on his or her behalf or a person with longstanding involvement in assuring the individual's health, safety, and welfare. A paid care provider may not be a consumer's representative.

CEP/SP Programs

- A CEP or SP consumer who is unable to meet his or her consumer-employer responsibilities may be required to designate a *Consumer-Employer (CE) Representative* (SDS 0737 form) to exercise those responsibilities.
- A CE Representative ***may not be*** a paid HCW providing in-home services to the individual.

ICP

- A participant in the ICP who is unable to meet his or her employer responsibilities may designate an ICP Representative (SDS 0737 form) to direct the participant's service plan, supervise employee providers, and manage their ICP cash payment accounting, tax, and payroll responsibilities.

- A representative must sign and abide by the responsibilities outlined in an *ICP Representative Agreement* and may not be a paid provider of services to the participant.
- An ICP Representative must complete and pass a background check prior to beginning their representative role.
- The Representative's name will need to be on the participant's ICP checking account along with the participant's name (Note: A licensed Fiscal Intermediary, accountant, payroll agency or tax professional do not have to complete the background check).

IHCAs

- When in-home services are provided by IHCA, an individual's representative is ***not*** indicated on the 737 form and is ***not*** considered a Consumer-Employer or Client Representative.
- A consumer receiving services through an IHCA may appoint an individual as their "representative" to participate in service planning duties on their behalf or appoint a natural support that has longstanding involvement in assuring the consumer's health, safety, and welfare.

WCM Services:

A direct or indirect contact (WCM service) is required each month for in-home consumers to maintain Medicaid eligibility. CMs provide direct and indirect waivered services with in-home consumers or their representatives, to promote person-centered care, develop service plans, mitigate and monitor risks, address concerns, and provide service options as needed.

- Direct WCM services involve face-to-face, or any form of back and forth communication such as a phone call or email communication between a consumer and a CM. Direct WCM services do not include contact with collateral contacts (family members, natural supports, etc.), unless the collateral contact is the individual's representative.
- Indirect WCM services involve communication between a consumer's collateral contacts or their representative and a CM.

CMs must complete a direct risk-focused contact monthly for in-home consumers identified with one or more high-risks (this includes MAGI recipients). If no high-risks have been identified, a risk-focused direct contact must be completed quarterly.

Procedures for In-Home Service Programs

Assessing Service Eligibility

- Consumer's must meet all the eligibility requirements in OAR 411-015-0010 through 411-0015-0100.
- Initial service eligibility is determined by a CM conducting an in-person CA/PS Title XIX assessment in Oregon ACCESS (OA) in the individual's home or care setting.
- To be determined eligible for services an individual must meet the criteria for service priority level (SPL) 1-13 as described in OAR chapter 411, division 015.
- The consumer must reside in a living arrangement described in OAR 411-030-0033.
- Individuals under 65 years of age with supporting documentation of a medical, non-psychiatric diagnosis, or physical disability, may be eligible for services based on their SPL level and medical determination.
- "Natural Support" (e.g. relatives, friends, significant others, neighbors, roommates, or the community), who provide voluntary assistance and services and have the skills,

knowledge, and ability to provide the needed services and supports, are identified during the assessment process.

Authorizing Service Eligibility

- The following are the possible Benefit types for the various In-Home programs:
  - APD - In Home
  - APD - SPH
  - ICP
  - KPS – In Home
  - KPS – SPH
  - OPI
- CMs create an In-home Service Plan (SDS 546N form) after approving the in-home service benefit and plans in CA/PS. A service plan is developed, and hours are authorized as determined by the consumer's assessed functional needs. A Service Planning and Notice (SPAN, SDS 2780N) and Assessment Summary (SDS 002N) are provided to the consumer.
- With the implementation of the Oregon, Provider Time Capture, Direct Care Innovations (OR PTC DCI) Electronic Visit Verification (EVV), new or updated authorizations for providers are completed in the MF per usual business process. Providers enter their time and mileage into the OR PTC DCI system (See APD-PT-21-025).
- The process for creating or updating authorizations in the MF remains the same. All new or ONGO generated authorizations will be automatically sent to OR PTC DCI.
- The CM will authorize hours by signing the SDS 546N.
- Authorized hours for an IHCA are set up as units in MMIS. Note: For IHCAs, the Task List must be agreed to and signed by the IHCA then returned to the CM before the IHCA can bill for authorized hours in MMIS.
- MMIS and ONE reflects a consumer's medical benefit eligibility. SELG to establish the services segments.
- The SELG (Service Eligibility) screen shows the results of a consumer's assessment and service eligibility record. SELG is updated when the CA/PS assessment is in completed status and the benefit and service plans are updated (approved or ended).
- Payment for HCWs is made through the MF screens (see Authorizations & Payments).

Forms and Systems: In-Home Services Program

Eligibility

CA/PS Assessment:

- Determines service priority levels (SPL 1 - 18). A consumer must meet SPL 1-13 to be eligible for services, unless they are Extended Eligibility Waiver (EWE) eligible (see OAR 411-015-0030).
- SPL Result and Needs Summary screen indicates the assessed need level and SPL results.
- Full Benefit Results screen displays the maximum assessed hours and SP results as well as the provider rates for the Assisted Living Facility (ALF), Residential Care Facility (RCF), and Adult Foster Home (AFH) levels.

CA/PS Service Planning:

- Benefits – approving and pushing the CA/PS assessment to complete sends a SELG record to the MF.

- Hours Segment – hours can be approved based on Tier 1, 2 or 3 security rights. CMs have Tier 1 rights. Supervisors/managers and some Lead workers have Tier 2 rights and can approve the Hour Segment as long as the hours for each need do not exceed the maximum allowed hours (73 ADL hours, 35 IADL hours). Tier 3 security rights are authorized to CO staff only. Information on these 3 tiers of security is found on the CM Tools site on the Oregon ACCESS and CA/PS Information page under OA Override Functions Processes and Tiered Security Information.
- In the CA/PS menu under Service Planning, the Benefit Eligibility and Service Planning sections show the Benefit plan, the providers, the assessed needs of the consumer, the assigned needs of the consumer, the assignment of hours to providers, 546 Details and Task List when opening the Provider Details screen. The Task List (598N) is printed from the printer icon on the tool bar in OA. The SPAN is accessible using the printer icon on the tool bar, not in the service planning area.

SELG MF and the CA/PS Service Category/Benefit:

- The Service Category/Benefit (Svc Cat) on the SELG MF screen is created by approving the CA/PS Benefit section in OA.
- SELG displays information such as CA/PS assessment results, provider payment levels, service eligibility information, and service category/benefit begin/end dates.

Authorization and Forms

(See Forms Server on the CM Tools page for forms related to in-home services and programs)

New or Updated Authorizations & Payments

- The process for creating or updating authorizations in the MF remains the same.
- All new or ONGO generated authorizations will be automatically sent to OR PTC DCI.
- Any authorizations that must be updated or changed after it was sent to OR PTC DCI must be manually updated in OR PTC DCI. **It is important to ensure that updated authorizations in OR PTC DCI match the MF record.** For example:
    - The HCW is not authorized to work for the entire pay period. The authorization must be deleted in OR PTC DCI and in the MF.
    - The authorized hours/mileage is increased or decreased for any reason. The OR PTC DCI authorization is modified, and a new authorization is created in the MF.
    - The authorization needs to end prior to the end of the pay period. The OR PTC DCI authorization end date is modified. The end date authorization in the MF is also modified.
- Providers will enter their time and milage into the OR PTC DCI system.
    - OR PTC DCI will evaluate each claim to determine if the claim is valid or not.
    - The Department has developed three-time capture options that are EVV compliant.
        - OR PTC DCI Mobile App - This is an application the HCW may download on their smart phone. The Department recommends that all HCWs utilize the OR PTC DCI mobile app to capture their time whenever possible.
        - OR PTC DCI Landline - The HCW calls the OR PTC DCI system by the individual's verified landline.
        - Fob Device - This is a remote device that is issued to the individual. The HCW presses a button on the fob when they begin and end their shift, which generates a unique code that the HCW enters OR PTC DCI web portal when entering the start and end of their shift.

- Mileage is entered by the provider into the OR PTC DCI provider web portal.
- Valid claims will be downloaded from OR PTC DCI.
  - OR PTC DCI will evaluate each claim to determine if the claim is valid or not.
  - Valid claims will be made available to download from OR PTC DCI (Punch Entries Report) to input into the STIM screen.
  - Once a claim has been downloaded, it will not be available for download again. It will be very important to properly track and process each download that is completed.
  - Local offices need to establish local business processes to determine:
    - • The frequency with which they pull the Punch Entries Report (Payroll Batch) from OR PTC DCI
    - When the claims are inputted into STIM
    - How the reports are saved
      - ✓ Using an agreed upon naming convention (Central Office recommends using Branch number_yyyy-mm-dd_military time)
      - ✓ Establishing an appropriate shared folder

MF Screens:
- HCW: ONGO
- IHCA: MMIS
- HDM: HPAY
- ADS: AATH, APAY

Provider Information:
- Prov Search OA is used to search for provider information.
- HINQ,provider # displays payment history for a particular provider.

Resources
Medicaid LTSS
- Oregon Supplemental Income Program

Assessments
- SPAN Notice Flow Chart
- OAR 411-015-0008
- Assessment Tools
- Client Details, Treatment Form & Misc. LTC Information
- Service Planning
- Service Priority Level (SPL) Information

Mental or Emotional Disorders (MED) Review Team
- MED Referrals and Processes
- OAR 411-015-0000 through 411-015-0100

CEP
- Consumer-Employed Provider (CEP) Specialist Manual
- The CEP Employers' Guide
- Homecare Worker Guide
- APD Field Support Assistance Manual (IV.B Customer Employed Provider (CEP) payment system)

Oregon ACCESS

- OA Override Functions, Processes and Tiered Security Information
- Oregon ACCESS Training Guide
- CA/PS SERVICES PER BENEFIT

MMIS Resources

- APD MMIS Resources
- Client Maintenance Unit (CMU) Information and Help

ICP

- ICP Worker Guide
- ICP Forms Processing Chart
- Coding for ICP

SPPC

- State Plan Personal Care Services – Exception Process
- State Plan Personal Care Services – General Information

SP

- Eligibility, Authorization, and Payments
- Eligibility Screen Shots (Eligible, Not Eligible)
- Spousal Pay Program Eligibility Determination Tool

Oregon Project Independence (OPI)

- OPI Service Plan Hours
- Community Services and Supports - OPI Webpage
- OPI Checklist