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NOTICE OF PROPOSED RULEMAKING

INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILED: 10/21/2026 7:38 PM
ARCHIVES DIVISION SECRETARY OF STATE

FILING CAPTION: Transitioning defined term “Client” to “Member”, “CCO Member”, or “Open Card Member” where appropriate.

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/21/2026 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:
Kelsey Gleeson
Rules Coordinator

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

DATE: 11/17/2026
TIME: 9:00 AM - 9:45 AM
OFFICER: Kelsey Gleeson

REMOTE HEARING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 669-254-5252
CONFERENCE ID: 1658671365
SPECIAL INSTRUCTIONS:
Meeting ID: 165 867 1365
Passcode: 215425

NEED FOR THE RULE(S):

In the Oregon Health Authority’s (OHA) external communications, the agency has referred to individuals receiving

services from the Oregon Health Plan (Medicaid) as a “Member” for many years. This rule language change aligns rule language with external communications.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE:

None

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

The purpose of this rule change is to improve plain language and grammar. These changes are consistently applied to all rules within chapter 410 (Medical Assistance Programs). The Oregon Health Authority does not expect a disproportional impact to racial equity within any specific community as a result of this rulemaking.

FISCAL AND ECONOMIC IMPACT:

The purpose of this rule change is to improve clarity, plain language, and grammar. These changes do not effect policy, operations, or service delivery. The Oregon Health Authority does not expect any fiscal or economic impact to any entity or individual as a result of this rulemaking.

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).
There is no expected economic impact.

(2) Effect on Small Businesses:
None.

(a) Estimate the number and type of small businesses subject to the rule(s);
None

(b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s);
None

(c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).
None.

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

Small businesses were invited with the general public to participate in the rules advisory committee.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? YES

RULES PROPOSED:
410-129-0020, 410-129-0070, 410-129-0075, 410-129-0080, 410-129-0100, 410-129-0220, 410-131-0080, 410-133-0340, 410-151-0040, 410-170-0000, 410-170-0020, 410-170-0050, 410-170-0060, 410-170-0070, 410-170-0080, 410-170-0090, 410-170-0100, 410-170-0110

AMEND: 410-129-0020

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-129-0020
Therapy Plan of Care, Goals, Outcomes, and Record Requirements ¶

(1) Therapy shall be based on a prescribing ~~p~~Practitioner's written order and therapy treatment plan with goals and objectives developed from an evaluation or re-evaluation. The limits, authorization, and plan of treatment criteria apply to both rehabilitative and habilitative therapy. The definition for both is the following:¶
(a) "Rehabilitative Services" means health care services that help an individual re-establish, restore, or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability;¶
(b) "Habilitative Services" means health care services that help an individual keep, learn, or improve skills and functioning for daily living, designed to establish skills that have not yet been acquired at an age-appropriate level. Examples include therapy for a child who is not walking or talking at the expected age.¶
(2) A total of ~~thirty (~~30~~)~~ visits per year of rehabilitative therapy and a total of ~~thirty (~~30~~)~~ visits per year of ~~h~~Habilitative ~~therapy~~Services (speech therapy) are included when ~~m~~Medically ~~a~~Appropriate. Additional visits, not to exceed ~~thirty (~~30~~)~~ visits per year of rehabilitative therapy and ~~thirty (~~30~~)~~ visits per year of habilitative therapy, may be authorized in cases of a new ~~a~~Acute injury, surgery, or other significant change in functional status. Children under age 21 may have additional visits authorized beyond these limits if ~~m~~Medically ~~n~~Necessary and ~~m~~Medically ~~a~~Appropriate, pursuant to 42 CFR § 441 Subpart B.¶
(3) The therapist shall teach the therapy regimen to individuals, including the ~~client~~Member, family members, foster parents, and caregivers who can assist in the achievement of the goals and objectives. The ~~client~~Member must be present when the therapy is appropriately demonstrated at the time of teaching to assure that the therapy regimen is performed safely and correctly. The Division may not authorize extra treatments for teaching.¶
(4) All Speech-Language Pathology (SLP) ~~treatment s~~Services require a therapy plan of care that is required for claims subject to prepayment review (PPR) or requiring Prior Authorization (PA) for payment.¶
(5) The Division shall provide authorization for the level of care or type of service that meets the ~~client~~Member's medical need consistent with the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (Prioritized List) and the American Hippotherapy Association's (AHA) position on coding and billing for equine related modalities.¶
(6) These rules do not limit or affect any obligations of a school district or education entity eligible for reimbursement for covered, health-related services provided in support of a child with a disability education program required by state and federal law. School-sponsored services are supplemental to other health plan therapy services and are not considered duplicative. See OAR chapter 410, division 133 SBHS rules for services provided by public education providers and OAR 410-141-3565 (Managed Care Entity (MCE) Billing).¶
(7) The SLP therapy plan must adhere to the licensing board requirements of care and shall include:¶
(a) ~~Client~~Member's name and ICD diagnosis code;¶
(b) The type, amount, frequency, and duration of the proposed rehabilitative or habilitative therapy;¶
(c) Individualized, measurably objective, short-term and long-term functional goals;¶
(d) Dated signature of the therapist or the prescribing ~~p~~Practitioner establishing the therapy plan of care; and¶
(e) Evidence of certification of the therapy plan of care by the prescribing ~~p~~Practitioner.¶
(8) SLP therapy records must be compliant with applicable record and documentation requirements (see Oregon Administrative Rules in chapter 335, division 010).¶
(9) Documentation of clinical activities may be supplemented using flowsheets or checklists; however, these may not substitute for or replace detailed documentation of assessments and interventions.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, ORS 414.065

AMEND: 410-129-0070

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-129-0070
Limitations ¶

(1) Speech Language Pathology (SLP) ~~s~~Services:¶
(a) Shall be provided by a ~~p~~Practitioner as described in OAR 410-129-0065;¶
(b) Requirements for rehabilitative and habilitative therapy treatment:¶
(A) Require Prior Authorization (PA) when it exceeds one hour per day each for a group or individual;¶
(B) Shall be either group or individual and may not be combined in the authorization period; and¶
(C) Require PA after ~~thirty (~~30~~)~~ habilitative and ~~thirty (~~30~~)~~ rehabilitative visits per calendar year.¶
(c) The following SLP services are not subject to prepayment review (PPR) and do not require PA but are limited to:¶
(A) Two SLP evaluations in a 12-month period;¶
(B) Two evaluations for dysphagia in a 12-month period;¶
(C) Up to four re-evaluations in a 12-month period;¶
(D) One evaluation for speech-generating/augmentative communication system or device (SGD) shall be reimbursed per recipient in a 12-month period;¶
(E) One evaluation for voice prosthesis or artificial larynx shall be reimbursed in a 12-month period;¶
(F) Purchase, repair, or modification of electrolarynx;¶
(G) Supplies for speech therapy shall be reimbursed up to two times in a 12-month period, not to exceed five dollars each.¶
(d) The purchase, rental, repair, or modification of a SGD requires PA. Rental of a SGD is limited to one month. All rental fees shall be applied to the purchase price.¶
(2) Audiology and hearing aid services:¶
(a) All hearing services shall be performed by a licensed ~~p~~Physician, ~~a~~Audiologist, or hearing aid specialist;¶
(b) Binaural hearing aids shall be reimbursed no more frequently than every five (5) years for individuals age 21 and older who meet the following criteria and medical necessity: Loss of 35 decibel (dB) hearing level or greater in two or more of the following frequencies: 1000, 2000, 3000, and 4000 Hertz (Hz);¶
(c) Binaural hearing aids shall be reimbursed no more frequently than every three (3) years for children, birth through age 20, who meet the following criteria:¶
(A) Pure tone average of 25dB for the frequencies of 500Hz, 1000Hz, and 2000Hz; or¶
(B) High frequency average of 35dB for the frequencies of 3000Hz, 4000Hz, and 6000Hz.¶
(d) An assistive listening device may be authorized for individuals aged 21 or over who are unable to wear or who cannot benefit from a hearing aid. An assistive listening device is defined as a simple amplification device designed to help the individual hear in a listening situation. It is restricted to a hand-held amplifier and headphones;¶
(e) The following services do not require PA:¶
(A) One basic audiologic assessment in a 12-month period;¶
(B) One basic comprehensive audiometry (audiologic evaluation) in a 12-month period;¶
(C) One hearing aid examination and selection in a 12-month period;¶
(D) One pure tone audiometry (threshold) test; air and bone in a 12-month period;¶
(E) One electroacoustic evaluation for hearing aid; monaural in a 12-month period;¶
(F) One electroacoustic evaluation for hearing aid; binaural in a 12-month period;¶
(G) Hearing aid batteries - maximum of 60 individual batteries in a 12-month period. ~~Client~~Members shall meet the criteria for a hearing aid.¶
(f) The following services require PA:¶
(A) Hearing aids;¶
(B) Repair of hearing aids, including ear mold replacement;¶
(C) Hearing aid dispensing and fitting fees;¶
(D) Assistive listening devices;¶
(E) Cochlear implant batteries:¶
(F) Bone anchored hearing aid (BAHA) replacement components.¶
(g) The following services require PA and must meet medical necessity and medical appropriateness under Early and Periodic Screening, Diagnostic and Treatment (EPSDT):¶

(A) FM systems;¶
(B) Vibro-tactile aids;¶
(C) Earplugs;¶
(h) Services not covered:¶
(A) Adjustment of hearing aids are included in the fitting and dispensing fee and is not reimbursable separately;¶
(B) Aural rehabilitation therapy is included in the fitting and dispensing fee and is not reimbursable separately;¶
(C) Tinnitus masker.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065, ORS 414.025

AMEND: 410-129-0075

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-129-0075
Face-to-Face Encounter Requirements for ~~Fee-for-Service Client~~Open Card Members
(1) For initial ordering of speech generating devices (SGD), an in-person, face-to-face encounter that is related to the primary reason the ~~client~~Member requires the medical equipment or supplies must occur no more than six months prior to the start of services:¶
(a) The face-to-face encounter shall be conducted and documented by the treating ~~p~~Physician (MD or DO) or an authorized non-~~p~~Physician ~~p~~Practitioner (NPP);¶
(b) Authorized NPPs for SGD are ~~n~~Nurse ~~p~~Practitioners, ~~c~~Clinical ~~n~~Nurse ~~s~~Specialists working in collaboration with a ~~p~~Physician, or ~~p~~Physician ~~a~~Associate under the supervision of a ~~p~~Physician;¶
(c) The ~~p~~Physician or NPP conducting the face-to-face encounter shall document that the ~~client~~Member is evaluated or treated for a condition that supports the need for the SGD ordered within six months prior to completing the written order for the equipment;¶
(d) If the NPP performing the face-to-face encounter does not have prescribing authority, the NPP shall communicate the clinical findings to the ordering ~~p~~Physician;¶
(e) The ordering ~~p~~Physician shall incorporate the clinical findings into a written or electronic document included in the ~~client~~Member's medical record.¶
(2) If a dually eligible ~~client~~Member is evaluated for medical equipment or supplies under Medicare and transitions to Medicaid, the Medicare face-to-face encounter documentation shall meet the Medicaid face-to-face requirement.¶
(3) The ~~d~~Durable ~~m~~Medical ~~e~~Equipment (DME) supplier shall maintain documentation of the qualifying face-to-face encounter and provide the documentation when the item requires PA or at the Division's request.¶
(4) The table at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/DME_List_of_Specified_Covered_Items_updated_March_26_2015.pdf identifies the DME items subject to these face-to-face requirements.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-129-0080

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-129-0080
Prepayment Review (PPR) and Prior Authorization (PA) for payment ¶

(1) Speech-language pathology, audiology, and hearing aid ~~p~~Providers are subject to PPR or shall obtain PA for services exceeding 30 habilitative and 30 rehabilitative visits in a calendar year.¶
(2) Providers shall request PA as follows (see the SLP, Audiology and Hearing Aid Services Program Supplemental Information booklet for contact information):¶
(a) For Medically Fragile Children's Unit (MFCU) ~~client~~Members, from the Authority's MFCU;¶
(b) For ~~client~~Open Card Members enrolled in the fee-for-service Medical Case Management program, from the Medical Case Management contractor;¶
(c) For ~~client~~Members enrolled in an MCE, from the MCE;¶
(d) For ~~client~~Members requiring visits in excess of 30 habilitative visits and 30 rehabilitative visits per calendar year.¶
(3) For services requiring PA, ~~p~~Providers shall contact the responsible unit for authorization within five working days following initiation or continuation of services. The ~~FAX~~fax or postmark date on the request shall be honored as the request date. It is the ~~p~~Provider's responsibility to obtain PA.¶
(4) For services subject to PPR and to ensure reimbursement of SLP services, beyond the initial evaluation, the SLP ~~p~~Provider must submit all required supporting documentation:¶
(a) Upon submission of the first claim in a series of claims in each therapy plan of care as established by prescribing ~~p~~Practitioner per OAR 410-129-0020 for claims subject to PPR;¶
(b) Request a PA within five working days following 30 rehabilitative or 30 habilitative visits within a calendar year if additional visits are necessary:¶
(A) PA requests dated within five working days may be approved retroactively to include services provided within five days prior to the date of the PA request;¶
(B) PA requests dated beyond five working days may not be authorized retroactively and if authorized shall be effective the date of the PA request. The Division recognizes the facsimile or postmark as the PA date of request.¶
(c) All claims subject to PPR or that requires PA must include a therapy plan of care; and¶
(d) A PA is not required for Medicare-covered SLP services provided to dual-eligible ~~client~~Members (Medicare ~~client~~Members who are also Medicaid-eligible).¶
(5) If the service or item is subject to PPR or requiring PA, the ~~p~~Provider shall follow and comply with PPR or PA requirements in these rules and the ~~G~~general ~~R~~rules (OAR chapter 410, division 120) including but not limited to:¶
(a) The service is adequately documented (see OAR 410-120-1360 Requirements for Financial, Clinical and Other Records). Providers shall maintain documentation in the ~~p~~Provider's files to adequately determine the type, medical appropriateness, or quantity of services provided;¶
(b) The services provided are consistent with the information submitted when authorization was requested;¶
(c) The services billed are consistent with those services provided;¶
(d) The services are provided within the timeframe specified on the authorization of payment document; and¶
(e) Includes the PA number on all claims for services that require PA, or the Division shall deny the claim.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, ORS 414.065

AMEND: 410-129-0100

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-129-0100
Medicare/Medicaid Claims ¶

(1) When an individual not in managed care has both Medicare and Medicaid coverage, audiologists shall bill audiometry and all diagnostic testings to Medicare first. Medicare will automatically forward these claims to Medicaid. Refer to OAR 410-120-1210 ~~(General Rules)~~ for information on Division or CCO reimbursement.¶
(2) Audiologists shall bill all hearing aids and related services directly to the Division on an OHP 505. Payment ~~a~~Authorization is required on most of these services.¶
(3) If Medicare transmits incorrect information to the Division, or if an out-of-state Medicare carrier or intermediary was billed, ~~p~~Providers shall bill the Division using an OHP 505 form. If any payment is made by the Division, an adjustment request shall be submitted to correct payment, if necessary.¶
(4) Send all completed OHP 505 forms to the Division.¶
(5) Hearing aid dealers shall bill all services directly to the Division on a CMS-1500. Payment ~~a~~Authorization is required on most services.¶
(6) When a ~~client~~Member not in managed care has both Medicare and Medicaid coverage, ~~s~~Speech-~~l~~Language ~~p~~Pathologists shall bill services to Medicare first. Medicare will automatically forward these claims to Medicaid. Refer to OAR 410-120-1210 ~~(General Rules)~~ for information on Division or CCO reimbursement.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.034, 414.065, 414.329, 414.706, 414.710

AMEND: 410-129-0220

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-129-0220
Augmentative Communications System or Device ¶

(1) Augmentative Communications System or Device and the necessary attachment equipment to bed or wheelchair are a covered benefit of the Division.¶
(2) The requested system or device shall be approved, registered, or listed as a medical device with the Food and Drug Administration.¶
(3) Criteria for coverage: Providers shall meet each of the following components and submit documentation to the Division with claims subject to PPR and with PA request for review:¶
(a) A ~~p~~Physician's statement of diagnosis and medical prognosis (not a prescription for an augmentative device) documenting the inability to use speech for effective communication as a result of the diagnosis;¶
(b) Reliable cognitive ability and a consistent motor response to communicate that can be measured by standardized or observational tools:¶
(A) Object permanence - ability to remember objects and realize they exist when they are not seen; and¶
(B) Means end - ability to anticipate events independent of those currently in progress - the ability to associate certain behaviors with actions that will follow.¶
(c) The ~~client~~Member shall be assessed by a SLP and when appropriate an ~~o~~Occupational ~~t~~Therapist or ~~p~~Physical ~~t~~Therapist. The evaluation report shall include:¶
(A) A completed OHA 3047 form: Augmentative Communication Device Selection Report Summary (page 1) and required elements of the Formal Augmentative/Alternative Communication Evaluation (page 2). Attach additional pages required to complete information requested;¶
(B) An explanation of why this device is best suited for this ~~client~~Member and why the device is the lowest level that will meet basic functional communication needs;¶
(C) Evidence of a documented trial of the selected device and a report on the ~~client~~Member's success in using this device; and¶
(D) A therapy treatment plan with the identification of the individual responsible to program the device and monitor and reevaluate on a periodic basis.¶
(d) Providers send requests for augmentative communications systems or devices to the Division; and¶
(e) The manufacturer's MSRP and the vendor's acquisition cost quotations for the device shall accompany each request including where the device is to be shipped.¶
(4) The Division shall reimburse for the lowest level of service that meets the medical need.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 413.042, ORS 414.065

AMEND: 410-131-0080

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate. Other housekeeping updates.

CHANGES TO RULE:

410-131-0080
Therapy Plan of Care and Record Requirements ¶

(1) There must be a rehabilitative or habilitative therapy plan of care to receive payment.¶
(2) The Division shall authorize for the level of care or type of service that meets the ~~client~~Member's medical need consistent with the ~~Health Evidence Review Commission's (HERC)~~OHA Prioritized List of Health Services (OHA Prioritized List) and guideline notes.¶
(3) The rehabilitative or habilitative therapy plan must adhere to the licensing board requirements of care and shall include:¶
(a) ~~Client~~Member's name, ICD diagnosis code, and type, amount, frequency, and duration of the proposed rehabilitative or habilitative therapy;¶
(b) Individualized, measurably objective functional goals;¶
(c) Documented need for extended service, considering 60 minutes as the maximum length of a treatment session;¶
(d) Plan to address implementation of a home management program as appropriate from the initiation of therapy forward;¶
(e) Dated signature of the therapist or the prescribing ~~p~~Practitioner establishing the therapy plan of care; and¶
(f) For home health ~~client~~Members, any additional requirements included in OAR chapter 410 division 127.¶
(4) The therapy treatment plan and regimen shall be taught to the ~~client~~Member, family, foster parents, or caregiver during the therapy treatments. The ~~client~~Member must be present for demonstrating therapy during teaching to assure therapy regimen is performed safely and correctly. The ~~d~~Division may not authorize extra treatments for teaching.¶
(5) A therapy plan must comply with the relevant state licensing authority's standards.¶
(6) If a state licensing authority has not adopted therapy plan of care standards, the therapy plan of care shall include:¶
(a) The need for continuing rehabilitative or habilitative therapy clearly stated;¶
(b) Changes to the rehabilitative or habilitative therapy plan of care, including changes to duration and frequency of intervention; and¶
(c) Any changes or modifications to the therapy plan of care shall be documented, signed, and dated by the prescribing ~~p~~Practitioner or therapist who developed the plan.¶
(7) Therapy records shall include:¶
(a) A written referral, including:¶
(A) The ~~client~~Member's name;¶
(B) The ICD-10-CM diagnosis code; and¶
(C) Specification of the type of services, amount, and duration required.¶
(b) A copy of the signed therapy plan of care must be on file in the ~~p~~Provider's therapy record prior to billing for services;¶
(c) Documents, evaluations, re-evaluations, and progress notes to support the rehabilitative or habilitative therapy treatment plan and prescribing ~~p~~Provider's written orders for changes in the therapy treatment plan;¶
(d) Modalities used on each date of service;¶
(e) Procedures performed, and amount of time spent performing the procedures, documented and signed by the therapist; and¶
(f) Documentation of splint fabrication and time spent fabricating the splint.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 688.135, 414.065

AMEND: 410-133-0340

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-133-0340
~~Client~~Member Rights and Record Confidentiality ¶

(1) School medical ~~p~~Providers must provide access to records and documentation that support claims submitted to the Authority for school-based health services provided to Medicaid-enrolled children and young adults when requested by the Authority, Oregon Department of Justice, Medicaid Fraud Unit, Oregon Secretary of State, or the United States Department of Health and Human Services, or their authorized representatives.¶
(2) ~~Client~~Member rights of confidentiality for Medicaid-enrolled children and young adults must be respected in accordance with the provisions of 42 CFR Part 431, Subpart F and ORS 411.320.¶
(3) School medical ~~p~~Providers are subject to the confidentiality laws applicable to student records, including student medical records maintained as part of the education record.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 192.410-192.505

AMEND: 410-151-0040

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-151-0040
Lead Screening
(1) All children enrolled in the Oregon Health Plan, including ~~F~~fee-for-~~S~~service and MCEs or CCOs, must have blood lead screening tests. Children with Medical Assistance Program coverage must have blood lead screening tests at age 12~~-~~-months and 24~~-~~-months. Any child between ages 24 and 72~~-~~-months with no record of a previous blood lead screening test must receive one. Completion of a risk assessment questionnaire does not meet the lead screening requirement for children under Medicaid.¶
(2) Method of Blood Collection: A single venous or capillary blood draw is acceptable for the blood lead screening test. A capillary blood lead level greater than or equal to 3.5 micrograms per deciliter must be confirmed with either a venous draw or a second capillary draw within 12 weeks.¶
(3) Blood lead levels greater than or equal to 3.5 micrograms per deciliter from a venous draw or two capillary blood lead tests greater than or equal to 3.5 micrograms per deciliter drawn within 12 weeks of each other in children under 18 years of age and pregnant or lactating ~~women~~individuals are defined as cases and initiate case management by the local public health authority. See the definition of "Blood lead level at or above the blood lead reference value" in OAR 333-017-0000.¶
(4) Billing of ~~l~~Laboratory ~~s~~Services is covered in~~:~~ OAR 410-130-0680.¶
(a) For the collection of blood, use CPT 36415 for a venipuncture sample or CPT 36416 for capillary puncture samples.¶
(b) To bill for venipuncture or capillary blood lead screening, use Current Procedural Terminology (CPT) code 83655.¶
(5) Health care ~~p~~Providers shall report all cases or suspected cases when blood lead levels are at or above the blood lead reference value to local public health authority within one working day and within seven (7) days when any blood lead level tests are performed including the result. See OAR 333-018-0015(3)(c)(A); OAR 333-018-0015(3)(d)¶
(6) All children, pregnant and lactating ~~women~~individuals with lead poisoning are eligible to receive follow up ~~c~~Case ~~m~~Management ~~s~~Services. See OAR 333-019-0000 and Oregon Health Authority Public Health Division's Oregon Lead Poisoning Investigative Guidelines at: https://www.oregon.gov/oha/PH/HealthyEnvironments/HealthyNeighborhoods/LeadPoisoning/CountyHealthDepartments/Documents/Diseaseguidelines.pdf.~~-~~¶
(7) The local public health authorities are eligible for investigation reimbursements. To bill for comprehensive lead investigation, use HCPCS code T1029. Payment for code T1029 includes the home investigation and any follow-up ~~c~~Case ~~m~~Management ~~s~~Services provided after the home investigation is completed. The Authority limits reimbursement of T1029 to one time per dwelling. For ~~clients enrolled in Fee-for-Service~~Open Card Members, the service is payable by the Authority for ~~d~~Dates of ~~s~~Service through September 30, 2020. Effective October 1, 2020 for ~~members enrolled in managed care plan~~CCO Members, the service is payable by the ~~managed care plan~~CCO.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.150

AMEND: 410-170-0000

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-170-0000
Administration of the Behavior Rehabilitation Services (BRS) Program ¶

(1) All BRS contractors shall, and ensure that their BRS ~~p~~Providers, comply with the Medical Assistance ~~p~~Programs rules in OAR ~~C~~chapter 410, ~~D~~division 120.¶
(2) All BRS contractors shall, and ensure that their BRS ~~p~~Providers, comply with the BRS program general rules in OAR ~~C~~chapter 410, ~~D~~division 170.~~-~~¶
(a) BRS contractors shall, and ensure that their BRS ~~p~~Providers, comply with OAR ~~C~~chapter 413, ~~D~~division 095 to provide services or placement-related activities to BRS ~~client~~Members who receive ~~p~~Prior ~~a~~Authorization from the Oregon Department of Human Services~~;~~ (ODHS);¶
(b) BRS contractors shall, and ensure that their BRS ~~p~~Providers, comply with OAR ~~C~~chapter 416, ~~D~~division 335 to provide services or placement-related activities to BRS ~~client~~Members who receive ~~p~~Prior ~~a~~Authorization from the Oregon Youth Authority~~.~~ (OYA).¶
(3) The Oregon Health Authority may delegate authority to another agency or a unit of government to carry out some of its obligations under these rules.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-170-0020

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-170-0020
Definitions ¶

The following definitions apply ~~to terms used in~~with respect to OAR ~~C~~chapter 410, ~~D~~division 170. The Oregon Health Authority (Authority) also incorporates the definitions in OAR 410-120-0000 for any terms not defined in this division of OARs.¶
(1) "Accreditation" as defined in OAR 413-095-0000(2) means:¶
(a) An endorsement certifying that the BRS program meets all of the rigorous guidelines for service and quality established by any of the following entities:~~-~~¶
(A) The Commission on Accreditation of Rehabilitation Facilities (CARF); or¶
(B) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or~~-~~¶
(C) The Council on Accreditation (COA); or~~-~~¶
(D) An independent, not for profit accrediting organization approved by the U.S. Department of Health and Human Services.¶
(b) A provisional endorsement issued by one of the entities described in section (a)(A)-(D) of this rule and conditionally approved by the Department for a period not to exceed 270 days from the date the provisional endorsement is issued.~~-~~¶
(2) "Aftercare and Transition Plan (ATP)" means the written individualized service plan developed by the BRS contractor or BRS ~~p~~Provider describing how the BRS ~~client~~Member will successfully transition from its program to the community and identifying the aftercare services that must be provided to the BRS ~~client~~Member following discharge.~~-~~¶
(3) "Aftercare and Transition Plan - Stabilization (ATP-S)" means the aftercare and transition plan developed in a short-term stabilization program.¶
(4) "Aftercare Planning" means the process of developing a detailed description of the services to be delivered to the BRS ~~client~~Member and the BRS ~~client~~Member's family, including fictive kin, through parent training during the aftercare period.¶
(5) "Age-Appropriate or Developmentally-Appropriate Activities" means activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral and social capacities that are typical for an age or age group. In the case of a specific child, age-appropriate or developmentally appropriate activities means activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, behavioral and social capacities of the child.¶
(6) "Agency" means the state agency that has a contract with the BRS contractor to provide services and placement-related activities to the BRS ~~client~~Member and provides ~~p~~Prior ~~a~~Authorization for the BRS ~~client~~Member to receive services and activities pursuant to the BRS program ~~general~~ rules and, as applicable, agency-specific BRS program rules. The agency is one of the following state agencies: ~~T~~the Oregon Department of Human Services (Department), the Oregon Health Authority (Authority), or the Oregon Youth Authority (OYA).~~-~~¶
(7) "Approved Proctor Foster Parent" means an individual who a BRS contractor, a BRS ~~p~~Provider, or OYA, approved to provide services or placement-related activities to the BRS ~~client~~Member in the home of that individual. Approved ~~p~~Proctor ~~f~~Foster ~~p~~Parents who provide services are considered direct care staff and shall meet those qualifications in OAR 410-170-0030. An OYA ~~a~~Approved ~~p~~Proctor ~~f~~Foster ~~p~~Parent is certified by OYA and a child-caring agency in accordance with the applicable provisions in OAR ~~C~~chapter 416, ~~D~~division 530 and ~~C~~chapter 416, ~~D~~division 550 and is employed by or has a contract or agreement with the child-caring agency to provide some services and placement-related activities to the BRS ~~client~~Member in the proctor foster parent's home.~~-~~¶
(8) "Abbreviated AER" means the assessment and evaluation report developed when there is a transfer of the BRS ~~client~~Member between BRS programs as described in OAR 410-170-0070(2)(d).¶
(9) "Assessment and Evaluation Report (AER)" means the written report detailing the findings of the assessment and evaluation of the BRS ~~client~~Member conducted by a social service staff member as required in OAR 410-170-0070(2).¶
(10) "Assessment and Evaluation Report - Stabilization (AER-S)" means the assessment and evaluation report

developed in a short-term stabilization program.¶
(11) "Behavior Rehabilitation Services (BRS) Program" means a program that provides services and placement-related activities to the BRS ~~client~~Member to address their debilitating psychosocial, emotional, and behavioral disorders in a community placement utilizing either a residential care model or a proctor care model.~~¶~~
(12) "Billable Care Day" means each calendar day the BRS ~~client~~Member is in the direct care of the BRS ~~p~~Provider at 11:59 p.m. or meets the requirements in OAR 410-170-0110.~~¶~~
(13) "BRS ~~Client~~Member" means the person who has ~~p~~Prior ~~a~~Authorization from an agency to receive services or placement-related activities through the BRS ~~p~~Program.~~¶~~
(14) "BRS Contractor" means the entity contracted with an agency to be responsible for providing services and placement-related activities to the BRS ~~client~~Member. The BRS ~~c~~Contractor may also be the BRS ~~p~~Provider if it provides direct services and placement-related activities to the BRS ~~client.~~ Member.¶
(15) "BRS Provider" means a facility, institution, corporate entity, or other organization that provides direct services and placement-related activities to the BRS ~~client.~~ Member.¶
(16) "BRS Type of Care" means the type of program model, services, placement-related activities, and staffing requirements and qualifications that are necessary to meet the medical and other needs of the BRS ~~client.~~ Members.¶
(17) "Caseworker" means the individual who coordinates the services and placement-related activities for the BRS ~~client~~Member with the BRS ~~c~~Contractor and BRS ~~p~~Provider.~~¶~~
(18) "Child" or "Children" means a person or persons under 21 years of age.~~¶~~
(19) "Child-Caring Agency" means a child-caring agency in ORS 418.205.~~¶~~
(20) "Children's Health Insurance Program (CHIP)" means the federal and state funded portion of the Oregon Health Plan (OHP) established by Title XXI of the Social Security Act and administered by the Authority.~~¶~~
(21) "Contract Administrator" means the employee or other individual designated in writing by the agency, by name or position description, to conduct the contract administration of a contract or class of contracts.¶
(22) "Crisis Intervention" means the BRS ~~c~~Contractor or the BRS ~~p~~Provider responding, either by phone or in-person, to a crisis or urgent need of the BRS ~~client~~Member or the BRS ~~client~~Member's aftercare resource for the purpose of providing aftercare services to the BRS ~~client.~~ Member.¶
(23) "Critical Event" means a significant event including incidents described in OAR 413-215-0091(11)(b) occurring in the operation of the BRS ~~c~~Contractor's or BRS ~~p~~Provider's program that is considered likely to cause complaints, generate concerns, or come to the attention of the media, law enforcement agencies, first responders, Child Protective Services, or other regulatory agency.¶
(24) "Culture" means the sum of attitudes, customs, values, and beliefs that distinguishes one group of people from another.¶
(25) "Culturally-Sensitive Approach" means to enhance practices with culturally appropriate strategies through the knowledge and interpersonal skills that allow the BRS ~~p~~Provider to understand, appreciate, engage, and work with individuals from their culture's perspective.¶
(26) "Designated LPHA" means a licensed practitioner of the healing arts who has a contract with, is approved by, or is employed by the agency to make a determination on the ~~m~~Medical ~~a~~Appropriateness of the BRS ~~p~~Program for the BRS ~~client.~~ ~~¶~~
~~(27) "~~Member.¶
(27) "Oregon Department of Human Services (Department)" means the agency established in ORS ~~C~~chapter 409, including such divisions, programs, and offices as may be established therein. For purposes of these rules, it refers to the Child Welfare Programs within the Department.~~¶~~
(28) "Direct Care Staff" means an individual who is employed by or who has a contract or an agreement with the BRS ~~p~~Provider and is responsible for assisting social service staff in providing individual and group counseling, skills-training and therapeutic interventions, and monitoring and managing the BRS ~~client~~Member's behavior to provide a safe, structured living environment that is conducive to treatment.~~¶~~
(29) "Evidence-Based" as defined in OAR 413-095-0000(4) means an approach to medicine, education, and other disciplines that emphasizes the practical application of the findings of the best available current research.¶
(30) "Face to Face" means a personal interaction where both words can be heard and facial expressions can be seen in person or through telehealth services where there is a live streaming audio and video to the extent appropriate and in the BRS ~~client~~Member's best interest.¶
(31) "Fictive Kin" as defined in OAR 413-095-0000(5) has the same meaning as kith and means an individual who is not related to the BRS ~~client~~Member by blood, adoption, or marriage but has an emotionally significant relationship with the BRS ~~client~~Member that has the characteristics of a family relationship.¶
(32) "Gender-Responsive Approach" means integrating those things that intentionally allow gender identity and development to affect and guide services and service delivery in order to create an environment (physical, social, emotional) that is responsive to the issues and needs of the BRS ~~client~~Member being served.~~¶~~
(33) "Home Visit" means planned in-person contact between the BRS ~~client~~Member and the BRS ~~client~~Member's

immediate family, extended family, ~~f~~Fictive ~~k~~Kin, prior foster family, or other natural support persons.¶
(34) "Initial Service Plan (ISP)" means the initial written individualized services plan developed by the BRS ~~c~~Contractor or BRS ~~p~~Provider identifying the services that must be provided to the BRS ~~client~~Member during the first 45 days in its BRS ~~p~~Program or until the master service plan is written.~~-~~¶
(35) "Licensed Practitioner of the Healing Arts (LPHA)" means a ~~p~~Physician or other ~~p~~Practitioner licensed in the ~~S~~state of Oregon who is authorized within the scope of the LPHA's practice, as defined under state law, to diagnose and treat individuals with physical or mental disabilities or psychosocial, emotional, and behavioral disorders.~~-~~¶
(36) "Master Service Plan (MSP)" means the written individualized services plan developed by the BRS ~~c~~Contractor or BRS ~~p~~Provider identifying the services that must be provided to the BRS ~~client~~Member in its BRS ~~p~~Program.~~-~~¶
(37) "Master Service Plan - Stabilization (MSP-S)" means the ~~m~~Master ~~s~~Service ~~p~~Plan developed in a short-term stabilization program.~~-~~¶
(38) "Master Service Plan - Transition (MSP-T)" means the ~~m~~Master ~~s~~Service ~~p~~Plan developed in an independent living program.¶
(39) "Medicaid" means the federal and state funded portion of the medical assistance programs established by Title XIX of the Social Security Act as amended and administered in Oregon by the Authority.~~-~~¶
(40) "Monitoring" means in-person, phone or electronic contact by the BRS ~~p~~Provider with the BRS ~~client~~Member and those defined in 410-170-0070(1)(a)(B) to check on progress for the purpose of aftercare services, based on the needs identified in the BRS ~~client~~Member's Aftercare and Transition Plan.¶
(41) "Non-Qualified Residential Treatment Program" means BRS Contractors and BRS ~~p~~Providers that provide services in a residential care model and that do not meet the requirements of a Qualified Residential Treatment Program.~~-~~¶
(42) "Oregon Health Authority (Authority)" means the agency established in ORS Chapter 413 that administers the funds for Titles XIX and XXI of the Social Security Act. It is the single state agency for the administration of the medical assistance program under ORS chapter 414.~~-~~¶
(43) "Oregon Youth Authority (OYA)" means the state department charged with the management and administration of youth correction facilities, state parole and probation services, and other functions related to state programs for youth offenders.¶
(44) "Physical Restraint" as defined in OAR 413-215-0076 means the act of restricting the BRS ~~client~~Member's voluntary movement as an emergency measure to manage and protect the ~~client~~Member or others from injury when no alternate actions are sufficient to manage the ~~client~~Member's behavior. Physical restraint does not include temporarily holding a ~~client~~Member to assist ~~hi~~them or ~~her or assure his or he~~assure their safety, such as preventing a child from running onto a busy street.~~-~~¶
(45) "Placement-Related Activities" means the BRS ~~c~~Contractor's and BRS ~~p~~Provider's activities related to the operation of the program and the care of the BRS ~~client~~Member as set forth in the BRS ~~p~~Program general rules, applicable agency-specific BRS program rules, the contract or agreement with the agency or the contractor, and applicable federal and state licensing and regulatory requirements. Placement-related activities may include but are not limited to providing the ~~client~~Member with food, clothing, shelter, daily supervision; access to educational, cultural, and recreational activities; and case management. Room and board is not funded by Medicaid or CHIP.~~-~~¶
(46) "Postvention" means the activities implemented by the BRS ~~c~~Contractor and the BRS ~~p~~Provider after a BRS ~~client~~Member's suspected suicide, including support for the bereaved family, friends, professionals, peers and those with geographic, social or social media ties to the deceased. In order to meet the needs of those bereaved by a suicide and to reduce the risk of contagion. Postvention includes the immediate postvention response implemented in the immediate days and weeks after a BRS ~~client~~Member's suspected suicide.¶
(47) "Proctor Care Model" means services and placement-related activities provided to the BRS ~~client~~Member who resides in the home of an ~~a~~Approved ~~p~~Proctor ~~f~~Foster ~~p~~Parent.~~-~~¶
(48) "Program Coordinator or Program Director" means an individual employed by or contracted with the BRS ~~p~~Provider and responsible for supervising staff, providing overall direction to the BRS ~~p~~Provider, planning and coordinating program activities and delivery of services and placement-related activities, and ensuring the safety and protection of the BRS ~~client~~Member and the BRS ~~p~~Provider's staff.~~-~~¶
(49) "Public Child-Caring Agency" means, for purposes of this rule, a program or institution operated by a governmental agency or unit other than the Department, OYA, or the Authority that provides care to the BRS ~~client~~Member in a residential community setting.~~-~~¶
(50) "Qualified ~~r~~Residential ~~t~~Treatment ~~p~~Program (QRTP)" means a program that:¶
(a) Provides residential care and treatment to a BRS ~~client~~Member who require specialized, evidence-based supports and services related to the effects of trauma or mental, emotional or behavioral health needs.¶
(b) Uses a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of the BRS ~~client~~Member.¶
(c) Ensures that the staff at the facility includes licensed or registered nurses licensed under ORS chapter 678 and other licensed clinical staff who:¶

(A) Provide care within their licensed scope of practice;¶
(B) Are on site according to the treatment model identified in subsection (b) of this section; and¶
(C) Are available 24-hours per day and seven (7) days per week.¶
(d) Facilitates the involvement of the BRS ~~client~~Member's family, including ~~f~~Fictive ~~k~~Kin, as defined in ORS 418.575, in the BRS ~~client~~Member's treatment program, to the extent appropriate and in the BRS ~~client~~Member's best interests.¶
(e) Facilitates outreach to the BRS ~~client~~Member's family, including ~~f~~Fictive ~~k~~Kin, as defined in ORS 418.575, documents how outreach is made and maintains contact information for any known biological relatives or ~~f~~Fictive ~~k~~Kin, as defined by the Department.¶
(f) Documents how the program integrates family, including ~~f~~Fictive ~~k~~Kin, into the BRS ~~client~~Member's treatment process, including after discharge, and how sibling connections are maintained.¶
(g) Provides discharge planning and family-based after-care support for at least six (6) months following the BRS ~~client~~Member's discharge from the program.¶
(h) Is accredited as outlined in OAR 413-095-0000(2).¶
(51) "Residential Care Model" means that services and placement-related activities are provided to the BRS ~~client~~Member in a residential community setting and not in the home of an ~~a~~Approved ~~p~~Proctor ~~f~~Foster ~~p~~Parent.¶
(52) "Respite Care" means a formally planned arrangement to relieve an ~~a~~Approved, ~~p~~ Proctor ~~f~~Foster ~~p~~Parent's responsibilities by an individual temporarily assuming responsibility for the care and supervision of the BRS ~~client~~Member in the home of the respite provider or approved proctor foster parent. Respite ~~c~~Care shall be 14 or fewer consecutive days.¶
(53) "Runaway Status" means the period of time when a BRS ~~client~~Member has left or failed to return to their BRS placement without prior approval or authorization and has not been discharged from the BRS ~~c~~Contractor's program. This definition is for the purpose of 410-170-0110(3)(c).¶
(54) "Seclusion" means the involuntary confinement of a BRS ~~client~~Member to an area or room from which the BRS ~~client~~Member is physically prevented from leaving.¶
(55) "Service Coordination" means coordination activities identified in the BRS ~~client~~Member's Aftercare and Transition Plan, including: meeting with BRS ~~client~~Member and BRS ~~client~~Member's family, including ~~f~~Fictive ~~k~~Kin, to develop and review goals; maintain or facilitate contact with service providers; and assist BRS ~~client~~Member and BRS ~~client~~Member's family in obtaining services for the purpose of aftercare services.¶
(56) "Services" means the treatment provided to the BRS ~~client~~Member in a BRS ~~p~~Provider's program, including but not limited to treatment planning, milieu therapy, individual and group counseling, skills-training, and parent training.¶
(57) "Social Service Staff" means an individual employed by or contracted with the BRS ~~p~~Provider and is responsible for case management and the development of the service plans for the BRS ~~client~~Member; individual, group, and family counseling; individual and group skills-training; assisting the direct care staff in providing appropriate treatment to the BRS ~~client~~Member; coordinating services with other agencies; and documenting the BRS ~~client~~Member's treatment progress.¶
(58) "Suspected Suicide" means a death of a BRS ~~client~~Member reported by a medical examiner or designee that is believed to have been caused by self-directed injurious behavior with an intent to die as a result of the behavior.¶
(59) "Total Daily Rate" means the total amount of the service payment and placement-related activities payment for a billable care day.¶
(60) "Transition Facilitator" means a social service staff employed by or contracted with the BRS ~~p~~Provider and responsible for overseeing and monitoring the BRS ~~client~~Member in the BRS ~~c~~Contractor's independent living program, either operated by itself or by its BRS ~~p~~Provider, which includes but is not limited to assisting with developing the BRS ~~client~~Member's service plans and identifying support resources.¶
(61) "Transition Planning" means the process of preparing for a BRS ~~client~~Member to successfully discharge from the BRS program into the community and is described in the ATP.¶
(62) "Transitional Visit" means an overnight visit by the BRS ~~client~~Member to another paid placement for the purpose of facilitating the BRS ~~client~~Member's transition during the last 90 days of placement.¶
(63) "Trauma-Informed Approach" means an approach that recognizes and responds to the impact of traumatic stress on BRS ~~client~~Members and any other significant persons involved with the BRS ~~client~~Member.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-170-0050

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-170-0050
Program Referrals and Admission to BRS Provider ¶

(1) After the BRS ~~client~~Member receives ~~p~~Prior ~~a~~Authorization for the BRS ~~p~~Program, the agency shall refer the BRS ~~client~~Member for admission to one or more BRS contractors or BRS ~~p~~Providers that provide the appropriate BRS type of care.~~-~~¶
(2) The agency shall provide the BRS ~~c~~Contractor or, as applicable, the BRS ~~p~~Provider with the following documents in the BRS ~~client~~Member's referral packet:~~-~~¶
(a) Information identifying the individual or entity with legal authority over the BRS ~~client~~Member, which may be the BRS ~~client~~Member's parent, guardian, or legal custodian;~~-~~¶
(b) Any prior evaluations, assessments, or other documents that provide background information about the BRS ~~client~~Member or that support the need for the BRS ~~client~~Member's current level of services; and~~-~~¶
(c) The caseworker's case plan describing necessary services or similar planning form for the BRS ~~client.~~ Member.¶
(3) The BRS ~~c~~Contractor or, as applicable, the BRS ~~p~~Provider shall make admission decisions for the BRS ~~client~~Member based on its agency-approved written admission criteria, unless provided with written authorization from the agency to accept a BRS ~~client~~Member who does not meet its admission criteria.~~-~~¶
(4) The BRS ~~c~~Contractor or, as applicable, the BRS ~~p~~Provider may not deny an eligible BRS ~~client~~Member admission to its program if a vacancy exists within the program at the time of referral and the BRS ~~client~~Member meets its agency-approved admission criteria, unless it receives written approval from the referring agency.~~-~~¶
(5) The BRS ~~c~~Contractor may not and shall ensure its BRS ~~p~~Providers do not deny an eligible BRS ~~client~~Member admission to its program for any of the following reasons:~~-~~¶
(a) The presence or absence of family members, or ~~f~~Fictive ~~k~~Kin, to support the placement;~~-~~¶
(b) The race, religion, sexual orientation, color, or national origin of the BRS ~~client~~Member involved;~~-~~¶
(c) The BRS ~~client~~Member's place of residence; or~~-~~¶
(d) The absence of an identified after-care resource.~~-~~¶
(6) The BRS ~~c~~Contractor shall, and ensure its BRS ~~p~~Provider, notifies the caseworker of its admission decision within five (5) business days of receiving the BRS ~~client~~Member's referral packet unless an earlier timeframe is required in agency-specific BRS rules. If the BRS ~~p~~Provider denies admission to the BRS ~~client~~Member, then it shall provide the caseworker with a written explanation.~~-~~¶
(7) The BRS ~~c~~Contractor shall, and ensure its BRS ~~p~~Provider, maintains documentation (either electronically or in hard copy) of all its admission decisions for BRS ~~client~~Members referred by an agency or BRS ~~c~~Contractor, which includes the following:~~-~~¶
(a) The name of the BRS ~~client~~Member referred;~~-~~¶
(b) The date the referral was received;~~-~~¶
(c) The reason the referral was accepted or denied; and~~-~~¶
(d) The date the referral was responded to in writing.~~-~~¶
(8) Intake Procedures:~~-~~¶
(a) On the day that the BRS ~~client~~Member is physically admitted to the BRS ~~c~~Contractor's or BRS ~~p~~Provider's program, its staff shall provide the BRS ~~client~~Member and, as applicable, the BRS ~~client~~Member's parent, guardian, or legal custodian with copies of the following policies:~~-~~¶
(A) Behavior management system policy;~~-~~¶
(B) Grievance policy;~~-~~¶
(C) BRS ~~client~~Member's and family's rights policies, including but not limited to visitation and communication policies and the policies regarding the search and seizure of the BRS ~~client~~Member's person, property, and mail;~~-~~¶
(D) Discharge polices, including but not limited to a discharge initiated by the BRS ~~client;~~ Member;¶
(E) Seclusion and physical restraint policies;~~-~~¶
(F) Suicide prevention policy and procedures; and~~-~~¶
(G) Medication management policy.~~-~~¶
(b) The BRS ~~c~~Contractor must ensure its program, either operated by itself or by its BRS ~~p~~Provider, maintains signed documentation indicating that the BRS ~~client~~Member and, as applicable, the BRS ~~client~~Member's parent, guardian, or legal custodian received and understood the information described in subsection (8)(a) of this rule;~~-~~¶
(c) If any of the policies described in subsection (8)(a) of this rule are individualized for a BRS ~~client~~Member and

differ from the program's standard documented practices, these variations shall be explained and documented and included in or attached to the BRS ~~client~~Member's service plan;~~-~~¶
(d) If the BRS ~~client~~Member's parent, guardian, or legal custodian is unavailable at the time of admission, the BRS ~~c~~Contractor shall ensure its program, either operated by itself or by its BRS ~~p~~Provider, documents in the BRS ~~client~~Member's case file that it forwarded this information to the BRS ~~client~~Member's parent, guardian, or legal custodian by facsimile, mail, or electronic mail within 48~~-~~ hours of the BRS ~~client~~Member's admission to the program.~~-~~¶
(9) The agency is responsible for notifying the BRS ~~c~~Contractor or BRS ~~p~~Provider of any changes to the information described in section (2) of this rule. In addition, the agency shall provide the BRS ~~c~~Contractor or BRS ~~p~~Provider with the following information:¶
(a) Applicable written authorizations by the BRS ~~client~~Member or the BRS ~~client~~Member's parent, guardian, or legal custodian consenting to the BRS ~~client~~Member's participation in the BRS ~~p~~Program;¶
(b) If applicable, the prepaid health plan or ~~c~~Coordinated ~~c~~Care ~~o~~Organization (CCO) in which the BRS ~~client~~Member is enrolled;¶
(c) The BRS ~~client~~Member's current medical information, medication regime, and other medical needs; and¶
(d) If applicable, the BRS ~~client~~Member's school information, parental contact information, or similar types of information.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-170-0060

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-170-0060
Discharge from the BRS Contractor or BRS Provider ¶

(1) Planned discharge initiated by the BRS ~~c~~Contractor, BRS ~~p~~Provider, or the agency:~~-~~¶
(a) Initiated by the BRS ~~c~~Contractor or BRS ~~p~~Provider:~~-~~¶
(A) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Providers, notify the caseworker in writing as soon as reasonably practicable regarding its intent to initiate the planned discharge of the BRS ~~client~~Member from its program;~~-~~¶
(B) Following notification, the BRS ~~c~~Contractor or BRS ~~p~~Provider and caseworker shall meet to discuss the case. If a discharge date can be agreed upon, the BRS ~~client~~Member shall be discharged on that date. If they cannot agree, the caseworker shall remove the BRS ~~client~~Member from the program within 30 days from the original written notice to the caseworker, resulting in the BRS ~~client~~Member's planned discharge.~~-~~¶
(b) Initiated by the agency:~~-~~¶
(A) The BRS ~~client~~Member's caseworker shall notify the BRS ~~c~~Contractor or BRS ~~p~~Provider in writing as soon as reasonably practicable regarding the agency's intent to initiate the planned discharge of the BRS ~~client~~Member from its program;~~-~~¶
(B) Following notification, the caseworker and the BRS ~~c~~Contractor or BRS ~~p~~Provider must meet to discuss the case. If a discharge date can be agreed upon, the BRS ~~client~~Member must be discharged on that date. If they cannot agree, the caseworker may remove the BRS ~~client~~Member from the program resulting in the BRS ~~client~~Member's planned discharge.~~-~~¶
(2) Emergency Discharge:~~-~~¶
(a) Initiated by the BRS ~~c~~Contractor or BRS ~~p~~Provider:~~-~~¶
(A) The BRS ~~c~~Contractor or BRS ~~p~~Provider may request the immediate discharge of a BRS ~~client~~Member from its program if, after contact with the agency staff, there is agreement that the BRS ~~client~~Member is a clear and immediate danger to self or others. In such situations, the caseworker must consider the notification a priority and respond to the BRS ~~c~~Contractor or BRS ~~p~~Provider as soon as practicable but no later than one (1) business day;~~-~~¶
(B) The BRS ~~c~~Contractor shall, and ensure its BRS ~~p~~Providers, discuss the BRS ~~client~~Member's continuation in, temporary removal from, or discharge from the program.~~-~~¶
(b) The agency may immediately remove the BRS ~~client~~Member from the BRS ~~c~~Contractor's or BRS ~~p~~Provider's program for any reason, resulting in the BRS ~~client~~Member's emergency discharge;~~-~~¶
(c) A parent or guardian with appropriate legal authority, as determined by the agency, may immediately remove the BRS ~~client~~Member from the BRS ~~c~~Contractor's or BRS ~~p~~Provider's program, resulting in the BRS ~~client~~Member's emergency discharge.~~-~~¶
(3) Discharge initiated by the BRS ~~client:~~ Member:¶
(a) The BRS ~~client~~Member may initiate discharge from the BRS ~~p~~Provider by submitting a written request to the BRS ~~c~~Contractor, BRS ~~p~~Provider, or caseworker:~~-~~¶
(A) If the request is submitted to the program, the BRS ~~c~~Contractor shall, and ensure its BRS ~~p~~Provider, submits immediate verbal or written notification to the caseworker and the agency's designated contact and, if applicable, the BRS ~~client~~Member's parent, guardian, or legal custodian to allow for alternate placement arrangements;¶
(B) The caseworker or the agency's designated contact shall make alternative placement arrangements within five (5) business days from receiving the request from the BRS ~~client~~Member or the notice from the BRS ~~c~~Contractor or BRS ~~p~~Provider, whichever is earlier.¶
(b) Subsection (3)(a) of this rule does not apply to ~~client~~Members less than 18 years old in a BRS placement that:¶
(A) Does not meet the definition of a "public institution" in 42 CFR 435.1010; or¶
(B) Meets the definitions of a "publicly operated community residence" or a "child-care institution" in 42 CFR 435.1010.¶
(c) Notwithstanding subsection (3)(a) of this rule, the ~~c~~Child's legal guardian may commit a ~~c~~Child to a BRS placement without the ~~c~~Child's consent or over the ~~c~~Child's objection (i.e., override the ~~c~~Child's decision to leave the BRS ~~p~~Program) if the following conditions are met:¶
(A) The ~~c~~Child is under the age of 18 and is not legally emancipated or married;¶
(B) The guardian has legal authority to make medical decisions for the ~~c~~Child; and¶
(C) The ~~c~~Child's placement is not the result of a court determination of delinquency.¶

(4) Discharge from a program does not impact a BRS ~~client~~Member's ~~p~~Prior ~~a~~Authorization for the BRS ~~p~~Program generally. A BRS ~~client~~Member may be referred to another BRS contractor or BRS ~~p~~Provider or request re-referral to the same program if the ~~p~~Prior ~~a~~Authorization remains valid and the BRS ~~client~~Member remains eligible for the BRS ~~p~~Program.~~-~~¶
(5) The agency may temporarily remove the BRS ~~client~~Member for any reason without resulting in a discharge from the BRS ~~c~~Contractor's or BRS ~~p~~Provider's program.~~-~~¶
(6) Storage of the BRS ~~client~~Member's personal property:~~-~~¶
(a) The BRS ~~c~~Contractor shall, and ensure its BRS ~~p~~Providers, store property belonging to the BRS ~~client~~Member in its program for up to 30 days in a secure location following discharge when the BRS ~~client~~Member exits the program without the ~~client~~Member's property;~~-~~¶
(b) The BRS ~~c~~Contractor shall, and ensure its BRS ~~p~~Providers, contact the BRS ~~client~~Member's caseworker as soon as possible to make arrangements for the property to be retrieved.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-170-0070

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-170-0070
BRS Service Planning ¶

(1) Initial Service Plan (ISP):-¶
(a) A BRS ~~c~~Contractor that provides services and placement-related activities in a Shelter, Independent Living program, Enhanced Structure Independent Living program, Proctor Care, Proctor Enhanced Services, Assessment and Evaluation, Basic Residential, Basic Rehabilitation, Intensive Residential, Intensive Rehabilitation, or Intensive Behavioral Support program shall, and require that its BRS providers:¶
(A) Ensure that a social service staff member completes a written ISP within two (2) business days of the BRS ~~client~~Member's admission to its program;-¶
(B) Provide an opportunity for the following individuals to participate in developing the BRS ~~client~~Member's ISP, including but not limited to the BRS ~~client~~Member, the BRS ~~client~~Member's family, ~~f~~Fictive ~~k~~Kin, social service staff, the BRS ~~client~~Member's caseworker, and any other significant individuals involved with the BRS ~~client;~~ Member;¶
(C) Obtain and maintain documentation that the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule were provided with the opportunity to participate in developing the ISP;-¶
(D) Obtain written approval of the ISP prior to its implementation from the caseworker and, as applicable and appropriate, the BRS ~~client~~Member and the BRS ~~client~~Member's parent, guardian, or legal custodian; and-¶
(E) Provide the services identified in the ISP during the first 45 days in the BRS ~~p~~Provider's program or until the MSP is written.-¶
(b) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider types listed in subsection (1)(a) of this rule, ensure that the ISP is individualized, developmentally appropriate, based on a thorough assessment of the BRS ~~client~~Member's referral information, and include at minimum the following:-¶
(A) A plan to address specific behaviors and needs identified in the referral information including the intervention to be used;-¶
(B) A plan for any overnight home visits and transitional visits;-¶
(C) The anticipated discharge date;-¶
(D) The anticipated type of placement at discharge;-¶
(E) Existing orders for medication and any prescribed treatments for medical conditions, mental health conditions, or substance abuse;-¶
(F) Any type of behavior management system that is used as an intervention; and-¶
(G) A plan for behavior management needs if needs are greater than usual for the program.-¶
(2) Assessment and Evaluation Report (AER):-¶
(a) A BRS ~~c~~Contractor that provides services and placement-related activities in a Shelter, Proctor Care, Proctor Enhanced Services, Assessment and Evaluation, Basic Residential, Basic Rehabilitation, Intensive Residential, Intensive Rehabilitation or Intensive Behavioral Support program shall, and require that its BRS ~~p~~Providers:¶
(A) Ensure that a social service staff member conducts a comprehensive assessment of the BRS ~~client~~Member and completes a written AER; and-¶
(B) Submit the written AER to the caseworker within 45 days of the BRS ~~client~~Member's admission to its program.-¶
(b) The BRS ~~c~~Contractor and the BRS ~~p~~Provider types listed in subsection (2)(a) of this rule must ensure that the AER includes information about the BRS ~~client~~Member regarding the following domains:-¶
(A) Legal custody and basis for custody;-¶
(B) Medical information including prescribed medications and dosages;-¶
(C) Family or ~~f~~Fictive ~~k~~Kin information including specific cultural factors;-¶
(D) Mental health information;-¶
(E) Alcohol and drug use both current and historical;-¶
(F) Educational needs;-¶
(G) Vocational services, if the BRS ~~client~~Member is 14 years of age or older;-¶
(H) Social living skills; and-¶
(I) Placement plans including home visits, transitional visits, anticipated discharge date, and placement resources.-¶
(c) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider types listed in subsection (2)(a) of this rule, ensure

that the AER describes the following:-¶
(A) Identified problems, reason for referral or placement, and pertinent historical information;-¶
(B) The BRS ~~client~~Member's behaviors, response to current services, and strengths and assets;-¶
(C) Significant incidents or interventions or both;-¶
(D) A plan for behavior management needs if needs are greater than usual for the program;-¶
(E) Identification of any service goals; and-¶
(F) Identified needs by assessment and history.-¶
(d) The BRS contractor shall, and require that its BRS provider types listed in section (2)(a) of this rule, ensure that the Abbreviated AERs meet the following requirements:¶
(A) If a BRS client is transferred to the current BRS program from another BRS program and the client's most recent AER is less than 90 days old, the current BRS contractor or BRS provider may submit an abbreviated AER to the caseworker within 30 days of the client's transfer to its program instead of the AER required in section (2) of this rule;-¶
(B) The BRS contractor shall, and require that its BRS provider types listed in section (2)(a) of this rule, ensure that an abbreviated AER includes at minimum the information in section (2)(b)(A) of this rule and any other specific information requested by the caseworker. If the information is available, the BRS contractor or BRS provider must also include the information in section (2)(b)(B) through (D) of this rule.-¶
(3) Master Service Plan (MSP):-¶
(a) A BRS contractor that provides services and placement-related activities in a Shelter, Community Step Down, Proctor Care, Proctor Enhanced Services, Assessment and Evaluation, Basic Residential, Rehabilitation, Intensive Residential, Intensive Rehabilitation, or Intensive Behavioral Support program shall, and require that its BRS provider:-¶
(A) Ensure that a social service staff member completes a written individualized MSP within 45 days of the BRS client's admission to its program;-¶
(B) Provide the opportunity for the individuals listed in section (1)(a)(B) of this rule to participate in developing the BRS client's MSP;-¶
(C) Obtain and maintain documentation that the individuals listed in section (1)(a)(B) of this rule were provided with the opportunity to participate in developing the MSP;-¶
(D) Obtain written approval of the MSP prior to its implementation from the caseworker and, as applicable and appropriate, the BRS client and the BRS client's parent, guardian, or legal custodian; and-¶
(E) Provide the services identified in the MSP.-¶
(b) The BRS contractor shall, and require that its BRS provider types listed in section (3)(a) of this rule, ensure that the MSP includes goals that are measurable and attainable within a specified time frame and address at minimum the following domains where need is indicated by the BRS client's assessment and history:-¶
(A) Legal custody and basis for custody;-¶
(B) Medical information including medications and dosages;-¶
(C) Family or ~~f~~Fictive ~~k~~Kin information including specific cultural factors;-¶
(D) Mental health information;-¶
(E) Alcohol and drug use both current and historical;-¶
(F) Educational needs;-¶
(G) Vocational needs;-¶
(H) Social living skills;-¶
(I) Placement plans including home visits, transitional visits, anticipated discharge date, and placement resources;-¶
(J) Other needs identified in the BRS ~~client~~Member's AER that do not fall in one of the other identified domains above; and-¶
(K) Completion criteria individualized for each BRS ~~client~~Member. Completion is defined by progress in acquiring pro-social behaviors, attitudes, and beliefs while in the program, and not engaging in behavior that seriously jeopardizes the safety of staff and other program participants.-¶
(c) The BRS ~~c~~Contractor and the BRS ~~p~~Provider types listed in subsection (3)(a) of this rule must ensure that the MSP is individualized and developmentally appropriate and includes:-¶
(A) Specifically stated and prioritized service goals for the BRS ~~client~~Member that include the caseworker's recommendations and goals that the BRS ~~client~~Member wants to achieve;-¶
(B) Specific interventions and services its program shall provide to address each goal, including the use of a behavior management system as an intervention and a plan for behavior management needs if needs are greater than usual for the program;-¶
(C) Staff responsible for providing the identified services;-¶
(D) Specifically stated behavioral criteria for evaluating the achievement of goals;-¶
(E) A timeframe for the completion of goals;-¶
(F) The method used to monitor the BRS ~~client~~Member's progress towards completing goals;¶

(G) Transition goals and planning; and¶
(H) Aftercare Services, including a detailed description of available services that may be offered to the BRS ~~client~~Member. These services can include but are not limited to crisis intervention, service coordination, monitoring, skills training and parent training.~~-~~¶
(d) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider types listed in subsection (3)(a) of this rule, clearly list in the MSP those needs identified in a BRS ~~client~~Member's AER that are to be addressed by an outside provider and then identify the outside provider that will be responsible for addressing those needs. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, facilitate the BRS ~~client~~Member's access to other providers whenever needs identified in the AER cannot be met within the scope of the services offered by its program;~~-~~¶
(e) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider types listed in subsection (3)(a) of this rule, also describe in the MSP any plan for the BRS ~~client~~Member to participate in overnight home visits or transitional visits, including but not limited to documenting when the home visits or transitional visits are to occur, identifying the frequency of the visits (up to a maximum of eight (8) days per month for a combination of home visits and transitional visits), and describing how the visits relate to the BRS ~~client~~Member's goals identified in the MSP. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, make every attempt to schedule home visits and transitional visits so that they do not conflict with services. Any deviation from the approved home visit and transitional visit plan requires prior written approval from the agency.~~-~~¶
(4) Master Service Plan 90 Day Updates:~~-~~¶
(a) A BRS ~~c~~Contractor that provides services and placement-related activities in a Shelter, Community Step Down, Proctor Care, Proctor Enhanced Services, Assessment and Evaluation, Basic Residential, Rehabilitation, Intensive Residential, Intensive Rehabilitation, or Intensive Behavioral Support program shall, and require that its BRS ~~p~~Provider:~~-~~¶
(A) Ensure that a social service staff member reviews and updates in writing the BRS ~~client~~Member's MSP no later than 90 days from the date the MSP was first finalized or the last time it was updated and every 90 days thereafter. Social service staff must review the MSP and update it in writing if necessary, earlier whenever additional information becomes available that suggests that other services should be provided;~~-~~¶
(B) Provide the opportunity for the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule to participate in developing the BRS ~~client~~Member's MSP updates;~~-~~¶
(C) Obtain and maintain documentation that the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule were provided with the opportunity to participate in developing the MSP updates;~~-~~¶
(D) Obtain written approval of an updated MSP prior to its implementation from the caseworker and, as applicable and appropriate, the BRS ~~client~~Member and the BRS ~~client~~Member's parent, guardian, or legal custodian; and~~-~~¶
(E) Provide the services identified in the most recent MSP update.~~-~~¶
(b) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider types listed in subsection (4)(a) of this rule, ensure that the written update to the MSP is individualized and developmentally appropriate and includes at minimum the following:~~-~~¶
(A) The BRS ~~client~~Member's progress towards achieving service goals;~~-~~¶
(B) The BRS ~~client~~Member's performance on the behavior management system;~~-~~¶
(C) The BRS ~~client~~Member's performance on any individualized plans developed to address specific behaviors;~~-~~¶
(D) Any modifications to services based on the BRS ~~client~~Member's new behaviors or identified needs;~~-~~¶
(E) Any changes regarding recommendations, the discharge date, and transition plans;~~-~~¶
(F) Aftercare Planning with a detailed description of the services to be delivered to the BRS ~~client~~Member and during the aftercare period; and¶
(G) A summary of incidents involving the BRS ~~client~~Member that have occurred since the last time the MSP was updated.~~-~~¶
(5) Aftercare and Transition Plan (ATP):~~-~~¶
(a) A BRS ~~c~~Contractor that provides services and placement-related activities in Community Step Down, Proctor Care, Proctor Enhanced Services, Independent Living, Enhanced Structure Independent Living Program Assessment and Evaluation, Basic Residential, Rehabilitation, Intensive Residential, Intensive Rehabilitation, or Intensive Behavioral Support shall, and require that its BRS ~~p~~Provider:~~-~~¶
(A) Ensure that a social service staff member develops and completes a written ATP at least 30 days prior to, or when there is insufficient notice, as close as possible to 30 days prior to the BRS ~~client~~Member's planned discharge incorporating information from the latest MSP;~~-~~¶
(B) Provide the opportunity for the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule and members of the service planning team to participate in developing the BRS ~~client~~Member's written ATP;~~-~~¶
(C) Obtain and maintain documentation that the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule and members of the service planning team were provided with the opportunity to participate in developing the written ATP;~~-~~¶
(D) Provide a copy of the written ATP to the individuals described in ~~section~~paragraph (1)(a)(B) of this rule and

members of the service planning team; and.¶
(E) Obtain written approval of the written ATP from the caseworker and, as applicable and appropriate, the BRS ~~client~~Member and the BRS ~~client~~Member's parent, guardian, or legal custodian.¶
(b) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Providers listed in subsection (5)(a) of this rule, ensure that the written ATP describes how the BRS ~~client~~Member will successfully transition from its program to the community, specifically addressing the period of 180 days after discharge from its program. The BRS ~~c~~Contractor and BRS ~~p~~Provider must ensure that the written ATP includes, at minimum, the following:.¶
(A) Identification of the BRS ~~client~~Member's individual needs and unmet goals;.¶
(B) Identification of the aftercare services and supports outside of its program that will be available for the 180-day time-period;.¶
(C) Identification of the individual or entity responsible for providing the aftercare services outside of its program; and.¶
(D) Identification of aftercare services and supports provided by the program to the BRS ~~client~~Member that will be available for the 180-day time period. These services may include crisis intervention, service coordination, monitoring, and skills training. Minimum contact schedule is one time per week for the first 30 days, two times per month for the next 60 days, and one time per month for the remaining 90 days. Document the type, duration, and description of contact in the record pertaining to the BRS ~~client.~~ Member.¶
(E) Schedule for regular telephone contact by BRS ~~p~~Provider staff with the BRS ~~client~~Member and, as applicable, the BRS ~~client~~Member's family, ~~f~~Fictive ~~k~~Kin, caseworker, or other identified significant individuals.¶
(c) The BRS ~~c~~Contractor shall and require that its BRS ~~p~~Providers listed in subsection (5)(a) of this rule, provide services identified in the ATP.¶
(d) The BRS ~~c~~Contractor and its BRS ~~p~~Provider types listed in subsection (5)(a) of this rule will not be required to provide aftercare services and supports if the BRS ~~client~~Member decline services or when the BRS ~~client~~Member transitions to another BRS ~~p~~Program. The BRS ~~c~~Contractor or BRS ~~p~~Provider is still required to complete a written ATP.¶
(e) The BRS ~~c~~Contractor or BRS ~~p~~Provider types listed in subsection (5)(a) of this rule may not be required to provide a written ATP under the following circumstances:.¶
(A) The agency, legal guardian, or custodian removes the BRS ~~client~~Member from the program with little or no notice and in a manner not in accordance with the existing ATP;.¶
(B) The BRS ~~client~~Member is discharged from the program on an emergency basis due to the BRS ~~client~~Member's behavior, runaway status without a plan to return to the program, or transfer to another program or higher level of care;.¶
(C) The BRS ~~client~~Member is discharged to another BRS ~~p~~Provider; or¶
(D) The BRS ~~client~~Member initiates an immediate voluntary discharge from the program.¶
(6) For a discharge summary, a BRS ~~c~~Contractor that provides services and placement-related activities in a Shelter, Community Step-down, Independent Living program, Enhanced Structure Independent Living program, Proctor Care, Proctor Enhanced Services, Assessment and Evaluation, Basic Residential, Rehabilitation Services, Intensive Residential, Intensive Rehabilitation, Short-Term Stabilization, or Intensive Behavioral Support program shall, and require that its BRS ~~p~~Provider, ensure that a social service staff member completes and provides a written discharge summary to the caseworker within 15 days following the BRS ~~client~~Member's planned or actual discharge from its program. The discharge summary must include the BRS ~~client'~~Members progress towards service goals.¶
(7) Aftercare Summary:¶
(a) A BRS ~~c~~Contractor that provides services and placement-related activities in a Community Step-down, Independent Living, Enhanced Structure Independent Living Program, Proctor Care, Proctor Enhanced Services, Assessment and Evaluation, Basic Residential, Rehabilitation Services, Intensive Residential, Intensive Rehabilitation, Short-Term Stabilization, and Intensive Behavioral Support program shall, and require that its BRS ~~p~~Provider:¶
(A) Ensure that a social service staff member completes and provides a written aftercare summary to the caseworker within 210 days following the BRS ~~client~~Member's discharge from its program;.¶
(B) Summarize the BRS ~~client~~Member's status and progress on the ATP for the 180 days following the ~~client~~Member's discharge from the BRS ~~p~~Provider, including but not limited to the ~~client~~Member's adjustment to the community and any further recommendations;¶
(C) Summarize the specific services provided by the BRS ~~c~~Contractor and BRS ~~p~~Provider for the 180 days following discharge to include a description of each type of service provided, number of service hours provided per month, and the names of individuals receiving the services.¶
(b) An aftercare summary is not required if the BRS ~~p~~Provider type listed in subsection (7)(a) of this rule was not required to complete an ATP under circumstances listed in ~~section~~paragraphs (5)(e)(A-~~E~~D) of this rule.¶
(8) Master Service Plan - Transition (MSP-T):¶

(a) A BRS ~~c~~Contractor that provides services and placement-related activities in an Independent living program or Enhanced Structure Independent Living program shall, and require that its BRS ~~p~~Provider:~~-~~¶
(A) Ensure that the transition facilitator completes with the BRS ~~client~~Member a standardized assessment of independent living skills prior to the development of the MSP-T;¶
(B) Ensure that a transition facilitator in collaboration with the BRS ~~client~~Member completes a written MSP-T within 30 days of the BRS client's admission to the program;¶
(C) Provide the services identified in the MSP-T;¶
(D) Provide the opportunity for the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule to participate in developing the BRS client's MSP-T;¶
(E) Ensure the MSP-T is individualized and developmentally appropriate and includes:¶
(i) Specifically stated and prioritized service goals for the BRS ~~client~~Member that include the caseworker's recommendations and goals that the BRS ~~client~~Member wants to achieve;~~-~~¶
(ii) Specific interventions and services the program shall provide to address each goal, including the use of a behavior management system as an intervention and a plan for behavior management needs if needs are greater than usual for the program;~~-~~¶
(iii) Staff responsible for providing the identified services;~~-~~¶
(iv) Specifically stated behavioral criteria for evaluating the achievement of goals;~~-~~¶
(v) A timeframe for the completion of goals;~~-~~¶
(vi) The method used to monitor the BRS ~~client~~Member's progress towards completing goals.¶
(b) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider type listed in subsection (8)(a) of this rule, obtain and maintain documentation that the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule were provided with the opportunity to participate in developing the MSP-T;~~-~~¶
(c) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider type listed in subsection (8)(a) of this rule, obtain and maintain written approval of the MSP-T prior to its implementation from the caseworker and, as applicable and appropriate, the BRS ~~client~~Member and the ~~client~~Member's parent, guardian, or legal custodian;~~-~~¶
(d) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider type listed in subsection (8)(a) of this rule, ensure that the MSP-T includes goals that are measurable and attainable within a specified time frame and address at minimum the following domains where need is indicated by an assessment of the BRS ~~client~~Member's referral information and history:~~-~~¶
(A) Legal custody and basis for custody;¶
(B) Medical information including medications and dosages;¶
(C) Family or ~~f~~Fictive ~~k~~Kin information including specific cultural factors;¶
(D) Mental health information;~~-~~¶
(E) Alcohol and drug use including relapse prevention;¶
(F) Educational needs;¶
(G) Vocational needs;¶
(H) Placement plans including home visits, transitional visits, anticipated discharge date, and placement resources;¶
(I) Social living skills needs, including barriers to building healthy social support, recreation, and community connection or membership (including planning for supportive relationships);¶
(J) Independent living skills needs, which may include barriers regarding the use of technology, finances, and consumer awareness, transportation planning and responsibility, and free-time supervision and structure.¶
(9) Master Service Plan - Transition 30-day Updates:¶
(a) The BRS ~~c~~Contractor of an Independent Living or Enhanced Structure Independent Living program shall, and require that its BRS ~~p~~Provider:¶
(A) Ensure that the transition facilitator in collaboration with the BRS ~~client~~Member reviews and updates in writing the BRS ~~client~~Member's MSP-T no later than 30 days from the date the MSP-T was first finalized or the last time it was updated and every 30 days thereafter;¶
(B) Provide an opportunity for the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule to participate in developing the BRS ~~client~~Member's MSP-T update;¶
(C) Obtain and maintain documentation that the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule were provided with the opportunity to participate in developing the MSP-T updates;~~-~~¶
(D) Obtain written approval of an MSP-T update prior to its implementation from the caseworker and, as applicable and appropriate, the BRS ~~client~~Member and the BRS ~~client~~Member's parent, guardian, or legal custodian; and~~-~~¶
(E) Provide the services identified in the most recent MSP-T update.~~-~~¶
(b) The BRS ~~c~~Contractor and its BRS ~~p~~Provider type listed in subsection (9)(a) of this rule, must ensure that the written MSP-T update is individualized and developmentally appropriate and includes at minimum the following:~~-~~¶
(A) The BRS ~~client~~Member's progress towards achieving service goals;~~-~~¶
(B) The BRS ~~client~~Member's performance on the behavior management system;~~-~~¶

(C) The BRS ~~client~~Member's performance on any individualized plans developed to address specific behaviors;~~-~~¶
(D) Any modifications to services based on the BRS ~~client~~Member's new behaviors or identified needs;~~-~~¶
(E) Any changes regarding recommendations, the discharge date, or aftercare and transition plans; and~~-~~¶
(F) A summary of incidents involving the BRS ~~client~~Member that have occurred since the last MSP-T update.~~-~~¶
(10) For an Initial Service Plan - Stabilization (ISP-S), a BRS ~~c~~Contractor that provides services and placement-related activities in a Short-term Stabilization program shall, and require that its BRS ~~p~~Provider:~~-~~¶
(a) Ensure that a social service staff completes a written ISP-S within two business days of the BRS ~~client~~Member's admission to the program;¶
(b) Provide an opportunity for the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule to participate in developing the BRS ~~client~~Member's ISP-S;¶
(c) Obtain and maintain documentation that the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule were provided with the opportunity to participate in developing the ISP-S;~~-~~¶
(d) Obtain written approval of the ISP-S prior to its implementation from the caseworker and, as applicable and appropriate, the BRS ~~client~~Member and the BRS ~~client~~Member's parent, guardian, or legal custodian;~~-~~¶
(e) Provide the services identified in the ISP-S during the BRS client's first 30 days in the program.¶
(f) Ensure that the ISP-S is individualized, developmentally appropriate, and based on a thorough assessment of the BRS ~~client~~Member's referral information, and includes at minimum the following:¶
(A) A plan to address specific behaviors and needs identified in the referral information including the intervention to be used;¶
(B) A plan for any overnight home visits and transitional visits;¶
(C) The anticipated discharge date;¶
(D) The anticipated type of placement at discharge;¶
(E) Existing orders for medication and any prescribed treatments for medical conditions, mental health conditions, or substance abuse;¶
(F) Any type of behavior management system used as an intervention;~~-~~¶
(G) A plan for behavior management needs if needs are greater than usual for the program;¶
(H) Objectives for placement as described by the caseworker; and¶
(I) Goals that are measurable and attainable within the first 30 days of the BRS ~~client~~Member's placement in the BRS ~~p~~Program.¶
(11) Assessment and Evaluation Report - Stabilization (AER-S):¶
(a) A BRS ~~c~~Contractor that provides services and placement-related activities in a short-term stabilization program shall, and require that its BRS ~~p~~Provider, ensure a social service staff member conducts an assessment of each BRS ~~client~~Member who is expected to remain in the program for more than 30 days;~~-~~¶
(b) A BRS ~~c~~Contractor and BRS ~~p~~Provider in a short-term stabilization program shall, after conducting the assessment, require that the staff member submit a written AER-S to the BRS ~~client~~Member's caseworker within 30 days from the date the ~~client~~Member was admitted into the program. The written AER-S shall include the following information about the BRS ~~client.~~ Member:¶
(A) A summary of the ~~client~~Member's problems and needs, the reason for referral or placement, and any pertinent historical information;¶
(B) Identified reasons for behavioral instability;¶
(C) Summary of BRS ~~client~~Member's readiness for return to previous placement or recommended placement;¶
(D) The BRS ~~client~~Member's behaviors, response to current services, and strengths and assets;¶
(E) Assessment of BRS ~~client~~Member's characteristics that may require service delivery modifications to ensure successful participation in BRS ~~services~~;¶
(F) Significant incidents or interventions or both;¶
(G) A plan for behavior management needs if needs are greater than usual for the program, if applicable.¶
(c) The BRS ~~p~~Program as described in subsection (11)(a) of this rule is not required to conduct an assessment or submit a written AER-S, as described in subsection (11)(b) of this rule, when the BRS ~~client~~Member is expected to remain in the program for 30 days or less.¶
(12) Master Service Plan - Stabilization (MSP-S):¶
(a) The BRS ~~c~~Contractor of a short-term stabilization program shall, and require that its BRS ~~p~~Provider:¶
(A) Ensure that a social service staff completes a written MSP-S within 30 days of the BRS ~~client~~Member's admission to the program;¶
(B) Provide an opportunity for the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule to participate in developing the BRS ~~client~~Member's MSP-S;¶
(C) Obtain and maintain documentation that the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule were provided with the opportunity to participate in developing the MSP-S;~~-~~¶
(D) Obtain written approval of the MSP-S prior to its implementation from the caseworker and, as applicable and appropriate, the BRS ~~client~~Member and the BRS ~~client~~Member's parent, guardian, or legal custodian;~~-~~¶

(E) Ensure that the MSP-S is individualized and based on the BRS ~~client~~Member's needs identified in the AER-S;~~-~~¶
(F) Provide the services identified in the current MSP-S.¶
(b) The BRS ~~c~~Contractor of a short-term stabilization program shall, and require that its BRS ~~p~~Provider, ensure that the MSP-S describes the following:¶
(A) Specifically stated and prioritized service goals for the BRS ~~client~~Member based on the AER-S that include the caseworker's recommendations and goals that the BRS ~~client~~Member wants to achieve;¶
(B) Medical information including medications and dosages.¶
(c) The BRS ~~c~~Contractor of a short-term stabilization program shall, and require that its BRS ~~p~~Provider, ensure that the MSP-S is individualized and developmentally appropriate and includes:~~-~~¶
(A) Specific interventions and services its program shall provide to address each goal, including the use of a behavior management system as an intervention and a plan for behavior management needs if needs are greater than usual for the program;~~-~~¶
(B) Staff responsible for providing the identified services;~~-~~¶
(C) Specifically stated behavioral criteria for evaluating the achievement of goals;~~-~~¶
(D) A timeframe for the completion of goals;~~-~~¶
(E) The method used to monitor the BRS ~~client~~Member's progress towards completing goals;~~-~~¶
(F) Aftercare and transition goals and planning, including anticipated discharge date and placement resource;~~-~~¶
(G) Completion criteria individualized for each BRS ~~client~~Member. Completion is defined by progress in acquiring pro-social behaviors, attitudes, and beliefs while in the program and not engaging in behavior that seriously jeopardizes the safety of staff and other program participants.~~-~~¶
(d) For the Assessment and Evaluation Report, the BRS ~~c~~Contractor of a short-term stabilization program shall, and require its BRS ~~p~~Provider, to identify in the MSP-S those needs identified in a BRS ~~client~~Member's AER-S that will be addressed by an outside provider and identify that provider. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, facilitate the BRS ~~client~~Member's access to other providers whenever needs identified in the AER-S cannot be met within the scope of the services offered by its program;~~-~~¶
(e) The BRS ~~c~~Contractor of a Short-term Stabilization program shall, and require that its BRS ~~p~~Provider, describe in the MSP-S any plan for the BRS ~~client~~Member to participate in overnight home visits and transitional visits, including but not limited to documenting when the home visits and transitional visits are to occur, identifying the frequency of the visits (up to a maximum of eight (8) days per month), and describing how the visits relate to the BRS ~~client~~Member's goals identified in the MSP-S. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, make every attempt to schedule home and transitional visits so that they do not conflict with services. Any deviation from the approved home visit and transitional visit plan requires prior written approval from the BRS ~~client~~Member's caseworker.¶
(13) Master Service Plan - Stabilization Updates (MSP-S):¶
(a) The BRS ~~c~~Contractor of a Short-term Stabilization program shall, and require that its BRS ~~p~~Provider:¶
(A) Ensure that a social service staff member reviews and updates in writing the BRS ~~client~~Member's MSP-S no later than 30 days from the date the MSP-S was first finalized or the last time it was updated and every 30 days thereafter. Social service staff must review the MSP-S and update it in writing earlier, if necessary, whenever additional information becomes available that suggests that other services should be provided;¶
(B) Provide the opportunity for the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule to participate in developing the BRS ~~client~~Member's MSP-S updates;¶
(C) Obtain and maintain documentation that the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule were provided with the opportunity to participate in developing the MSP updates;¶
(D) Obtain written approval of an updated MSP-S prior to its implementation from the caseworker and, as applicable and appropriate, the BRS ~~client~~Member and the BRS ~~client~~Member's parent, guardian, or legal custodian; and¶
(E) Provide the services identified in the most recent MSP-S update.¶
(b) The BRS ~~c~~Contractor of a Short-term Stabilization program shall, and require that its BRS ~~p~~Provider, ensure that the written update to the MSP-S is individualized and developmentally appropriate and includes at minimum the following:¶
(A) The BRS ~~client~~Member's progress towards achieving service goals;¶
(B) The BRS ~~client~~Member's performance on the behavior management system;¶
(C) Any modifications to services based on the BRS ~~client~~Member's new behaviors or identified needs;¶
(D) Any changes regarding recommendations, the discharge date, or aftercare and transition plans; and¶
(E) A summary of incidents involving the BRS ~~client~~Member that have occurred since the last time the MSP-S was updated.¶
(14) Aftercare and Transition Plan - Stabilization (ATP-S):¶
(a) The BRS ~~c~~Contractor of a Short-term Stabilization program shall, and require that its BRS ~~p~~Provider:¶
(A) Ensure that a social service staff member develops and completes a written ATP-S at least 30 days prior to or as

close as possible to the BRS ~~client~~Member's planned discharge;¶
(B) Provide the opportunity for the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule and members of the service planning team to participate in developing the BRS ~~client~~Member's written ATP-S;¶
(C) Obtain and maintain documentation that the individuals listed in ~~section~~paragraph (1)(a)(B) of this rule and members of the service planning team were provided with the opportunity to participate in developing the written ATP-S;¶
(D) Provide a copy of the written ATP-S to the individuals described in ~~section~~paragraph (1)(a)(B) of this rule and members of the service planning team; and¶
(E) Obtain written approval of the written ATP-S from the caseworker and, as applicable and appropriate, the BRS ~~client~~Member and the ~~client~~Member's parent, guardian, or legal custodian.¶
(b) The BRS ~~c~~Contractor of a short-term stabilization program shall, and require its BRS ~~p~~Provider, ensure the written ATP-S describes how the BRS ~~client~~Member is successfully transitioning from its program to the community, specifically addressing the period of 180 days after discharge from its program. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, ensure the written ATP-S includes, at minimum, the following:¶
(A) Identification of the BRS ~~client~~Member's individual needs and unmet goals;¶
(B) Identification of the aftercare services and supports outside of its program that are available for the 180-day time-period;¶
(C) Identification of the individual or entity responsible for providing the aftercare services.¶
(D) Identification of aftercare services and supports provided by the BRS ~~p~~Program to the BRS ~~client~~Member that will be available for the 180-day time period. These services may include crisis intervention, service coordination, monitoring, and skills training. Minimum contact schedule is one time per week for the first 30 days, two times per month for the next 60 days, and one time per month for the remaining 90 days. Document the type, duration, and description of contact in the record pertaining to the BRS ~~client.~~Member.¶
(E) Schedule for regular telephone contact by BRS ~~p~~Provider staff with the BRS ~~client~~Member and, as applicable, the BRS ~~client~~Member's family, fictive kin, caseworker, or other identified significant individuals.¶
(c) The BRS ~~c~~Contractor of a short-term stabilization program shall, and require that its BRS ~~p~~Provider, complete an ATP-S for BRS ~~client~~Members who are being discharged home or into a non-BRS foster care placement;¶
(d) The BRS ~~c~~Contractor or BRS ~~p~~Provider will not be required to provide aftercare services and supports if the BRS ~~client~~Member decline services as documented in the ATP-S. The BRS ~~c~~Contractor or BRS ~~p~~Provider is still required to complete an ATP-S.¶
(e) The BRS ~~c~~Contractor or BRS ~~p~~Provider of a short-term stabilization program may not be required to provide a written ATP-S under the following circumstances:¶
(A) The agency, legal guardian, or custodian removes the BRS ~~client~~Member from the program with little or no notice and in a manner not in accordance with the current service plan;¶
(B) The BRS ~~client~~Member is discharged from the program on an emergency basis due to the BRS ~~client~~Member's behavior, runaway status without a plan to return to the program, or transfer to another program or higher level of care; or¶
(C) The BRS ~~client~~Member initiates an immediate voluntary discharge from the program.¶
(15) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, ensure that all BRS service plans described in this rule are developed and maintained in the BRS ~~client~~Member's case file in accordance with the timeframes and criteria in this rule, unless otherwise exempted.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-170-0080

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate. Other housekeeping updates.

CHANGES TO RULE:

410-170-0080
Services ¶

(1) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide services to the BRS ~~client~~Member in accordance with the BRS ~~client~~Member's service plan.~~-~~¶
(2) BRS ~~c~~Contractor staff shall, and require that its BRS ~~p~~Provider, staff structure and directly supervise all services.¶
(3) Types of Services:~~-~~¶
(a) Milieu Therapy:¶
(A) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide the BRS ~~client~~Member structured activities and planned interventions designed to normalize psycho-social development, promote safety, stabilize environment, and assist in responding in developmentally appropriate ways;~~-~~¶
(B) The program's staff shall monitor the BRS ~~client~~Member in these activities, which include developmental, recreational, academic, rehabilitative, or other productive work;~~-~~¶
(C) Milieu therapy occurs in concert with one of the other types of services. Because milieu therapy must occur in concert with another BRS service, the BRS ~~c~~Contractor may not and shall ensure that its BRS ~~p~~Provider does not count milieu therapy in the number of hours of BRS services provided to the BRS ~~client~~Member per week.¶
(b) For crisis counseling, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide the BRS ~~client~~Member counseling on a 24-hour basis to stabilize the ~~client~~Member's behavior until the problem can be resolved or assessed and treated by a qualified mental health professional or licensed medical ~~p~~Practitioner;~~-~~¶
(c) For individual and group counseling, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide face-to-face individual or group counseling sessions to the BRS ~~client~~Member that are designed to remediate the problem behaviors identified in the ~~client~~Member's service plan;~~-~~¶
(d) For parent training, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide planned activities or interventions (face-to-face or by telephone) to the BRS ~~client~~Member's family or identified aftercare resource family. Parent training is designed to assist the family in identifying the specific needs of the BRS ~~client~~Member, support the ~~client~~Member's efforts to change, and improve and strengthen parenting knowledge or skills indicated in the service plan as being necessary for the ~~client~~Member to return home or to another community living resource;~~-~~¶
(e) For skills-training, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide the BRS ~~client~~Member planned individual or group sessions using evidence-based or evidence-informed approaches or models designed to improve specific areas of functioning in the ~~client~~Member's daily living as identified in the service plan. Skills-training may be designed to develop appropriate social and emotional behaviors, improve peer and family relationships, improve self-care, encourage conflict resolution, reduce aggression, improve anger control, and reduce or eliminate impulse and conduct disorders.~~-~~¶
(f) For ~~F~~face-to-face services described in subsections (3)(c-d) of this rule the BRS ~~c~~Contractor shall, and require it's BRS ~~p~~Provider to, provide them in accordance with the definition standards described in OAR 410-170-0020(30). Any barriers BRS ~~c~~Contractors or their BRS ~~p~~Providers encounter when attempting to meet these standards including, but not limited to, temporary technical issues, health and safety precautions, or ~~client~~Member preference should be documented in service notes and attempts should be made to mitigate barriers as they arise.¶
(4) Telehealth for Behavior Rehabilitation Services:¶
(a) To utilize telehealth for services required by the BRS ~~p~~Program, the BRS ~~c~~Contractor and BRS ~~p~~Providers shall:¶
(A) Comply with Telehealth for Behavioral Health requirements described in OAR 410-172-0850;~~-~~¶
(B) Comply with ~~p~~the OHA Prioritized ~~l~~List of ~~h~~Health ~~s~~Services guidelines for telephone and e-mail consultation described in OAR 410-141-3830; and¶
(C) Comply with agency specific BRS Telehealth program rules and policies.¶
(b) The BRS ~~c~~Contractor and BRS ~~p~~Providers shall develop written ~~t~~Telehealth policy that complies with ~~section~~paragraphs (4)(a)(A-C) of this rule. At minimum, the policy shall describe:~~-~~¶
(A) The circumstances the provider may provide BRS ~~services~~ via ~~t~~Telehealth;~~-~~¶
(B) The telecommunication technologies the BRS ~~c~~Contractor or BRS ~~p~~Provider has implemented to deliver

services via ~~t~~Telehealth; and¶
(C) The process to obtain an individual's informed consent in accordance with ORS 107.154, 179.505, 179.507, 192.515, including a sample form.¶
(c) The BRS ~~c~~Contractor and BRS ~~p~~Providers may utilize ~~t~~Telehealth for services that require a face-to-face setting when there is a documented barrier to providing in-person services, as follows:¶
(A) Services via ~~t~~Telehealth shall be provided by a qualified program staff within their scope of position;¶
(B) Service notes for phone, individual or group counseling shall follow the same criteria as face-to-face counseling and identify the session was conducted by ~~t~~Telehealth and the reason for the use of ~~t~~Telehealth; and¶
(C) Individual or group counseling via ~~t~~Telehealth shall meet HIPAA and 42 CFR Part 2 standards for privacy; and¶
(D) Any barriers to meeting the standards set in the face-to-face definition found in OAR 410-170-0020(30), including but not limited to temporary technical issues, health and safety precautions, or ~~client~~Member preference should be documented in service notes and attempts should be made to mitigate barriers as they arise.~~-~~¶
(5) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider:~~-~~¶
(a) Provide a combination of services necessary to comply with the BRS ~~client~~Member's service plan and the requirements in OAR 410-170-0090 for the appropriate BRS type of care;~~-~~¶
(b) Create and maintain written documentation describing the services provided to each BRS ~~client~~Member that includes at a minimum the following information:~~-~~¶
(A) Name of the BRS ~~client;~~ Member;¶
(B) Date of ~~s~~Service;~~-~~¶
(C) Name and position of the staff member providing the service to the BRS ~~client;~~ Member;¶
(D) Length of time staff spent providing the service to the BRS ~~client;~~ Member;¶
(E) Description of the service provided; and~~-~~¶
(F) Description of the BRS ~~client~~Member's participation in the service.~~-~~¶
(c) Create and maintain a written weekly record in each BRS ~~client~~Member's case file with the total number of service hours provided each day to the ~~client~~Member and a breakdown of the number of hours spent providing each type of service described in section (3) of this rule; and~~-~~¶
(d) Ensure that social service staff review the documentation described in this section each week for quality, content, and appropriateness with the BRS ~~client~~Member's service plan.
Statutory/Other Authority: ORS 413.042, ORS 414.065, ORS 743A.058
Statutes/Other Implemented: ORS 414.065

AMEND: 410-170-0090

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-170-0090
BRS Types of Care ¶

(1) Shelter, Community Step-Down, and Independent Living Program:~~-~~¶
(a) The BRS ~~c~~Contractor or BRS ~~p~~Provider may use either a residential care model or proctor care model for these BRS types of care;~~-~~¶
(b) The BRS ~~c~~Contractor providing one of these BRS types of care shall, and require that its BRS ~~p~~Provider, ensure that a minimum of six (6) hours of services are available per week to each BRS ~~client~~Member as follows:~~-~~¶
(A) One hour of individual counseling or individual skills-training provided by social service staff; and~~-~~¶
(B) Five (5) hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.~~-~~¶
(c) The BRS ~~client~~Member is placed in a shelter type of care as a short-term intervention to develop necessary skills;¶
(d) The BRS ~~client~~Member is placed in a community step-down type of care from a higher BRS level of care following a thorough Assessment and Evaluation Report and when the BRS ~~client~~Member requires only six (6) BRS hours of service but the same level of BRS structure and support;¶
(e) The BRS ~~client~~Member placed in an independent living program type of care requires a structured, supervised setting prior to transitioning to a supported community placement or living independently.¶
(2) Enhanced Structure Independent Living Program:¶
(a) This BRS type of care follows a residential care model;~~-~~¶
(b) The BRS ~~c~~Contractor providing this BRS type of care shall, and require that its BRS ~~p~~Provider, ensure that a minimum of six hours of services are available per week to each BRS ~~client~~Member as follows:~~-~~¶
(A) One (1) hour of individual counseling or individual skills-training provided by social service staff; and~~-~~¶
(B) Five (5) hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.~~-~~¶
(c) The BRS ~~client~~Member placed in an enhanced structure independent living program type of care requires a structured, supervised setting with increased staff supervision and support prior to transitioning to a supported community placement or living independently.¶
(d) The BRS ~~client~~Member placed in an independent living program type of care requires a structured, supervised setting prior to transitioning to a supported community placement or independent living.¶
(3) Proctor Care, Proctor Enhanced Services, Assessment and Evaluation Proctor:~~-~~¶
(a) These BRS types of care follow a proctor care model;¶
(b) The BRS ~~c~~Contractor providing one of these BRS types of care shall, and require that its BRS ~~p~~Provider, ensure that a minimum of 11 hours of services are available per week to each BRS ~~client~~Member as follows:~~-~~¶
(A) Two (2) hours of individual counseling or individual skills-training, one of which is provided by social service staff; and~~-~~¶
(B) Nine (9) hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.~~-~~¶
(c) The BRS ~~client~~Member placed in proctor care types of care requires structure, behavior management, and support services to develop the skills necessary to be successful in a less restrictive home setting with an ~~a~~Approved ~~p~~Proctor ~~f~~Foster ~~p~~Parent;¶
(d) The BRS ~~client~~Member placed in proctor enhanced services types of care requires enhanced structure during the daytime hours. This level of care provides the structure of day treatment for necessary skill development with a less restrictive home setting with an ~~a~~Approved ~~p~~Proctor ~~f~~Foster ~~p~~Parent;~~-~~¶
(e) The BRS ~~client~~Member is placed in assessment and evaluation proctor type of care to identify deficiencies and develop necessary skills.¶
(4) Basic Residential, Rehabilitation Services, Intensive Residential, Intensive Rehabilitation Services, Assessment and Evaluation Residential, Short-Term Stabilization:~~-~~¶
(a) These types of care follow a residential care model. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide 24-hour supervision of the BRS ~~client~~Member by ensuring that at least one direct care staff is on duty and awake whenever a BRS ~~client~~Member is present in its program;~~-~~¶
(b) The BRS ~~c~~Contractor providing these BRS types of care shall, and require that its BRS ~~p~~Provider, ensure that a

minimum of 11 hours of services are available per week to each BRS ~~client~~Member as follows:~~-~~¶
(A) Two (2) hours of either individual counseling or individual skills-training, one of which is provided by social service staff; and~~-~~¶
(B) Nine (9) hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.~~-~~¶
(c) The BRS ~~client~~Member placed in basic residential BRS types of care requires the structure, behavior management, and support services of a residential care model for necessary skill development;¶
(d) The BRS ~~client~~Member placed in rehabilitation services types of care requires the structure, behavior management, and support services of a residential care model for necessary skill development;¶
(e) The BRS ~~client~~Member is placed in assessment and evaluation residential BRS type of care to identify deficiencies and develop necessary skills;¶
(f) The BRS ~~client~~Member placed in intensive residential or intensive rehabilitation services BRS types of care requires more intensive structure, behavior management, and support services than a BRS ~~client~~Member in the basic residential or rehabilitation BRS types of care;¶
(g) The BRS ~~client~~Member placed in short-term stabilization BRS type of care requires short-term intervention to provide behavioral stabilization.¶
(5) Intensive Behavioral Support:¶
(a) This type of care follows a residential care model. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide 24-hour supervision of the BRS ~~client~~Member by ensuring that at least one direct care staff is on duty and awake whenever a BRS ~~client~~Member is present in its program;¶
(b) The BRS ~~c~~Contractor providing this level of care shall, and require that its BRS ~~p~~Provider, ensure that a minimum of 11 hours of services are available per week to each BRS ~~client~~Member as follows:¶
(A) Three (3) hours of individual counseling or individual skills-training, two (2) hours of which are provided by social service staff; and~~-~~¶
(B) Eight (8) hours of any combination of individual or group counseling, crisis counseling, skills-training, or parent training.¶
(c) BRS ~~client~~Members placed in the intensive behavioral support type of care have difficulty re-regulating their emotions due to the presence of complex developmental trauma or other mental health concerns. They require skill training and intensive behavioral support.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-170-0100

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-170-0100
Placement-Related Activities for the Authoritys BRS Contractors and BRS Providers ¶

(1) In cases where the Authority is the agency, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide the following placement-related activities and all facilities, personnel, materials, equipment, supplies and services, and transportation necessary to provide those activities including but not limited to:~~-~~¶
(a) For transportation, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, be responsible for the transportation of the BRS ~~client~~Member to attend school to the extent not provided by the school district. For transportation to medical, dental, and therapeutic appointments to the extent not provided through the Oregon Health Plan; to recreational and community activities; to places of employment; and to shop for incidental items;~~-~~¶
(b) For educational and vocational activities, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, have a system in place to meet the educational and vocational needs of the BRS ~~client~~Member in its program either on-site or at an off-site location or a combination of the two;~~-~~¶
(c) Recreational, social, and cultural activities:~~-~~¶
(A) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide recreation time for the BRS ~~client~~Member daily and offer activities that are varied in type to allow BRS ~~client~~Members to obtain new experiences. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, document recreation as having been provided by recording the type of activity the BRS ~~client~~Member participated in and the date it occurred;~~-~~¶
(B) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide each BRS ~~client~~Member at least one opportunity per week to participate in recreational activities in the community, unless the BRS client is clearly unable to participate in offsite activities due to safety issues. If a BRS ~~client~~Member is restricted from participation in community recreation, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, document the reason in the BRS ~~client~~Member's case file, and the reason must be reviewed regularly to ensure that the BRS ~~client~~Member is not unnecessarily restricted from offsite activities. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, offer any BRS ~~client~~Member who is restricted from community activities alternative opportunities for recreation on-site;~~-~~¶
(C) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide access to or make available social and cultural activities for the BRS ~~client~~Members as part of the therapeutic milieu of the program. These activities are to promote the BRS ~~client~~Member's normal development and help broaden the BRS ~~client~~Member's understanding and appreciation of the community, arts, environment, and other cultural groups;~~-~~¶
(D) The BRS ~~c~~Contractor must not, and ensure that its BRS ~~p~~Provider does not, permit BRS ~~client~~Members to participate in recreational activities that present a higher level of risk to BRS ~~client~~Members without pre-approval by the caseworker. This applies to activities that require a moderate to high level of technical expertise to perform safely, present environmental hazards, or where special certification or training is recommended or required such as: whitewater rafting, rock climbing, ropes courses, activities on or in any body of water where a certified lifeguard is not present and on duty, mountain climbing, and using motorized yard equipment.~~-~~¶
(d) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, provide adequate opportunities for the BRS ~~client~~Members to complete homework assignments with assistance from staff if needed.~~-~~¶
(2) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, facilitate the BRS ~~client~~Member's access to other providers whenever identified needs are not met within the scope of services offered by the program. If health care services are needed but the program is unable to access the needed services for the BRS ~~client~~Member, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, immediately notify the caseworker about this in writing and document its unsuccessful efforts to access healthcare for the BRS ~~client~~Member in the BRS ~~client~~Member's case file:¶
(a) If there is no record that the BRS ~~client~~Member received a physical examination within the six (6) months immediately prior to the BRS ~~client~~Member's placement with its program, the BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, ensure or make every effort to ensure that the BRS ~~client~~Member receives a general medical checkup consistent with the OHP or health insurance allowances within 30 days of placement. The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, keep documentation of this procedure in the BRS ~~client~~Member's file and send a copy to the BRS ~~client~~Member's caseworker;¶
(b) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, ensure that services are provided for each BRS ~~client~~Member's mental health, physical health (including alcohol and drug treatment services), dental, and vision

needs. This does not include paying the cost of services or medications that are covered by the OHP or by the BRS ~~client~~Member's ~~t~~Third ~~p~~-Party private insurance coverage. For services or medications not covered by OHP or ~~t~~Third ~~p~~-Party private insurance, the BRS ~~c~~Contractor shall, and ensure that its BRS ~~p~~Provider, notify and work with the caseworker to resolve payment issues;¶
(c) The BRS ~~c~~Contractor shall, and require that its BRS ~~p~~Provider, administer and monitor medications consistent with all applicable licensing rules and the program's own medication management policy.¶
(3) The Authority's BRS ~~c~~Contractor, if not also the BRS ~~p~~Provider, is responsible for ensuring its BRS ~~p~~Provider provides the placement-related activities to the BRS ~~client~~Member as described in this rule.
Statutory/Other Authority: ORS 413.042, 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-170-0110

RULE SUMMARY: Changing “client” and “recipient” to “Member” or “CCO Member” or “Open Card Member” where appropriate.

CHANGES TO RULE:

410-170-0110
Billing and Payment for Services and Placement-Related Activities ¶

Effective July 1, 2025:¶
(1) The BRS ~~c~~Contractor is compensated for a billable care day (service and placement-related activities rates) on a fee-for-service basis, except as otherwise provided for in these rules. The Authority does not make payments for any calendar day that does not meet the definition of a billable care day under this rule.¶
(2) Billable care day rates are provided in the "BRS Rates Table," dated July 1, 2025, which is adopted as Exhibit 1 and incorporated by reference into this rule. The BRS Rates Table is available at http://www.oregon.gov/oha/HSD/OHP/Pages/Policy-BRS.aspx. A printed copy may be obtained from the agency. BRS contractors not meeting the QRTP requirements will be paid at the non-QRTP rate.¶
(3) Billable Care Day:¶
(a) For purposes of computing a billable care day, the BRS ~~client~~Member must be in the direct care of the BRS ~~c~~Contractor or BRS ~~p~~Provider at 11:59 p.m. of that day, be on runaway status as defined in this rule or be on an authorized home or transitional visit in accordance with section (4) of this rule;¶
(b) A billable care day does not include any day where the BRS ~~client~~Member is in detention, an inpatient in a ~~h~~Hospital, or has not yet entered or is discharged from the BRS ~~c~~Contractor's or BRS ~~p~~Provider's program;¶
(c) A billable care day does not include any day in which a BRS ~~client~~Member is on runaway status and the BRS ~~c~~Contractor or BRS ~~p~~Provider was responsible for less than an accumulated period of ~~8~~eight (8) hours for the primary care, support, safety, and well-being of the BRS ~~client~~Member.¶
(4) Home and Transitional Visits:¶
(a) The BRS ~~c~~Contractor and BRS ~~p~~Provider shall include only a maximum of eight (8) calendar days of a combination of home and transitional visits in a month, as billable care days;¶
(b) In order to qualify as an authorized home or transitional visit day, the BRS ~~c~~Contractor and BRS ~~p~~Provider must:¶
(A) Ensure that the home or transitional visit is tied to the BRS ~~client~~Member's service plan;¶
(B) Work with the BRS ~~client~~Member and the BRS ~~client~~Member's family, including ~~f~~Fictive ~~k~~Kin, or aftercare resource on goals for the home or transitional visit and receive regular reports from the family or aftercare resource on the BRS ~~client~~Member's progress while on the visit;¶
(C) Have staff available to answer calls from the BRS ~~client~~Member and BRS ~~client~~Member's family, including ~~f~~Fictive ~~k~~Kin, or aftercare resource and to provide services to the BRS ~~client~~Member during the time planned for the home or transitional visit if the need arises;¶
(D) Document communications with the BRS ~~client~~Member's family, including ~~f~~Fictive ~~k~~Kin, or aftercare resource; and¶
(E) Document the BRS ~~client~~Member's progress on goals set for the home or transitional visits.¶
(5) Invoice form:¶
(a) The BRS ~~c~~Contractor shall submit a monthly billing form to the agency in a format acceptable to the agency on or after the first day of the month following the month in which it provided services and placement-related activities to the BRS ~~client~~Member. The billing form must specify the number of billable care days provided to each BRS ~~client~~Member in that month;¶
(b) The BRS ~~c~~Contractor shall provide upon request, in a format that meets the agency's approval, written documentation of each BRS ~~client~~Member's location for each day claimed as a billable care day;¶
(c) The BRS ~~c~~Contractor shall submit only claims for billable care days consistent with the agency's ~~p~~Prior ~~a~~Authorization.¶
(6) Payment for a Billable Care Day:¶
(a) The agency shall pay the service and placement related activities rates to the BRS ~~c~~Contractor for each billable care day in accordance with the BRS Rates Table described in section (2) of this rule;¶
(b) Notwithstanding subsection (6)(a) of this rule, the Authority shall pay only the service rate for each billable care day to a public child-caring agency who by rule or contract provides the local match share for Medicaid claims under OAR 410-120-0035 and 42 CFR 433 Subpart B. The Authority may not pay the placement related activities rate for each billable care day to these types of public child-caring agencies;¶
(c) To the extent the payment for services is funded by Medicaid and CHIP funds:¶

(A) The BRS ~~c~~Contractor and the BRS ~~p~~Provider are subject to Medicaid billing and payment requirements in these rules and the Authority's general rules (OAR ~~C~~chapter 410, ~~D~~division 120);¶
(B) Payment using Medicaid and CHIP funds may be made only to the originating BRS ~~c~~Contractor and not to the aftercare resource.¶
(d) To be eligible as a QRTP and receive the QRTP rate, the BRS ~~c~~Contractor and the BRS ~~p~~Provider are required to:¶
(A) Meet the QRTP definition in OAR 410-170-0020; and¶
(B) Submit accreditation documentation in writing annually to the contract administrator; and¶
(C) Maintain compliance as described in OAR 410-170-0030(11)(L).¶
(7) Third-~~-~~Party Resources:¶
(a) The Authority's BRS ~~c~~Contractors must make reasonable efforts to obtain payment first from other resources consistent with OAR 410-120-1280;¶
(b) The Department's and OYA's BRS ~~c~~Contractors are not required to review or pursue ~~t~~Third-~~p~~-Party ~~r~~Resources. The Department and OYA must make reasonable efforts to obtain payment first from other resources consistent with OAR 410-120-1280 for Medicaid-eligible BRS ~~client~~Members.¶
(8) Public child-caring agencies who are responsible by rule or contract for the local match share portion of eligible Medicaid claims must comply with OAR 410-120-0035 and 42 CFR 433 Subpart B.¶
(9) In cases where the BRS ~~c~~Contractor is not also the BRS ~~p~~Provider, the BRS ~~c~~Contractor is responsible for compensating the BRS ~~p~~Provider for billable care days pursuant to the agency-approved subcontract between the BRS ~~c~~Contractor and the BRS ~~p~~Provider.¶
(10) The Authority may not be financially responsible for the payment of any claim that the Centers for Medicare and Medicaid Services (CMS) disallows under the Medicaid or CHIP program. If the Authority previously paid the agency or BRS ~~c~~Contractor for any claim that CMS disallows, the payment shall be recouped pursuant to OAR 410-120-1397. The Authority shall recoup or recover any other ~~o~~Overpayments as described in OAR 410-120-1397 and 943-120-0350 and 943-120-1505.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

RULE ATTACHMENTS MAY NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

NOTE: Attachments referenced are attached to this document. You may view the attachment 410-170-0110.pdf from the Attachments panel. Alternately, you may view the attachments at the following link: https://secure.sos.state.or.us/oard/viewAttachment.action?ruleVrsnRsn=340989