DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 415

Case Management Services for Individuals with Intellectual or Developmental Disabilities

411-415-0010 Statement of Purpose
(Adopted 06/29/2016)

(1) The rules in OAR chapter 411, division 415 prescribe standards, responsibilities, and procedures for the delivery of case management services to individuals with intellectual or developmental disabilities.

(2) Providers of case management services are limited to employees of --

(a) A Community Developmental Disabilities Program (CDDP);

(b) A Support Services Brokerage (Brokerage);

(c) Other public or private agencies contracted by a local community mental health authority; or

(d) The Department of Human Services, Office of Developmental Disabilities Services.

(3) Case management services are delivered using person-centered practices to assist individuals in accessing needed medical, employment, social, educational, and other services. Case management services include, but are not limited to:

(a) Assessment and periodic reassessment of individual needs and preferences;

(b) Development and periodic revision of the Individual Support Plan;

(c) Referral and related activities;

(d) Monitoring; and

(e) Follow-up activities.

(4) Services provided under these rules are intended to identify, strengthen, expand, and where required, supplement private, public, formal, and informal support available to individuals with intellectual or developmental disabilities. The case management services described in these rules encourage the exercising of self-determination in the design and direction of the individual receiving services.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695

411-415-0020 Definitions and Acronyms
(Temporary Effective 09/01/2016 to 02/27/2017)

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 415:

(1) "Affiliated Entity" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies, and insurance companies), or a political subdivision or instrumentality, including a municipal corporation of a state, that has an incident of ownership in the CME.

(2) "Case Management Contact" means a reciprocal interaction between a case manager and an individual or the legal or designated representative of the individual (as applicable).

(3) "Case Management Services" mean the functions performed by a case manager that are funded by the Department. Case management services include, but are not limited to:

(a) Assessment of support needs;

(b) Developing an ISP or Annual Plan that may include authorized services;

(c) Information and referral for services; and

(d) Monitoring the effectiveness of services and supports.

(4) "Case Manager" means the person who delivers case management services who meets the qualifications of OAR 411-415-0040 and is employed:

(a) As a Personal Agent by a Brokerage;

(b) As a Services Coordinator by a CDDP; or

(c) As a Services Coordinator by the Department.

(5) "CDDP" means "Community Developmental Disabilities Program".

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

(7) "CME" means "Case Management Entity". A CME includes the following:

(a) A CDDP.

(b) A Brokerage.

(c) CIIS.

(d) The Children's Residential Program of the Department.

(8) "Geographic Service Area" means the area within the state of Oregon where a CME is approved to provide developmental disabilities services. The geographic service area for a CDDP is the county.

(9) "IEP" means "Individualized Education Program".

(10) "Incident of Ownership" means an ownership interest, an indirect ownership interest, or a combination of direct and indirect ownership interest.

(11) "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in another entity. Indirect ownership interest includes an ownership interest in an entity that has an indirect ownership interest in another entity.

(12) "Initial ISP" means the first ISP:

(a) For an individual who is newly entered into case management services; or

(b) Following a period when the individual did not have an authorized ISP.

(13) "Initial Level of Care" means the first level of care determination:

(a) For an individual who is newly accessing Community First Choice state plan or waiver services; or

(b) Following a period when the individual was not determined to meet level of care.

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

(15) "Level of Care" means ICF/IDD Level of Care, Hospital Level of Care, or Nursing Facility Level of Care, as defined in OAR 411-317-0000.

(16) "OHP" means "Oregon Health Plan".

(17) "Owner" means a person with an ownership interest.

(18) "Ownership Interest" means the possession of equity in the capital, stock, or profits of an entity.

(19) "SSI" means "Supplemental Security Income".

(20) "These Rules" mean the rules in OAR chapter 411, division 415.

(21) "Transition Period" means the first 60 days after an individual enters a new program type, setting, or CME.

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411-415-0030 Eligibility for Case Management Services - Entry, Exit, Transfers
(Adopted 06/29/2016)

(1) Individuals determined eligible for developmental disabilities services may not be denied case management services or otherwise discriminated against on the basis of age, diagnostic or disability category, race, color, creed, national origin, citizenship, income, or duration of Oregon residence.

(2) To be eligible for case management services, an individual must be determined eligible for developmental disabilities services by a CDDP as described in OAR 411-320-0080.

(a) An adult who is eligible for case management services who lives in his or her own or family home may select to have case management services provided by a CDDP or a Brokerage, when the Brokerage has the capacity to provide the service according to OAR 411-340-0110. When a local Brokerage is selected, but the local Brokerage does not have the capacity to provide case management, case management must be delivered by the local CDDP until the local Brokerage has capacity.

(b) A child or adult selecting services from a residential program may only have case management services delivered by a CDDP or the Department.

(c) A child who is eligible for and receives family support services as described in OAR chapter 411, division 305 may only have case management services delivered by a CDDP.

(d) A child who is eligible for and enrolled in a CIIS program as described in OAR chapter 411, division 300 may only have case

management services delivered by the Department, and by the CDDP with respective roles identified in the ISP.

(e) In order to receive case management services, an individual, or as applicable the legal representative of the individual, must accept the following supports:

(A) Assistance from a CME with the design and management of Department-funded services and supports;

(B) Abuse investigations;

(C) The presence of a case manager at required entry or exit meetings;

(D) Monitoring of services (when applicable) in accordance with OAR 411-415-0090;

(E) Case management contacts as described in OAR 411-415-0090; and

(F) Case manager access to the service record.

(3) To be eligible for case management services delivered by a CIIS services coordinator, an individual must meet the eligibility requirements for a CIIS program in OAR 411-300-0120 and be enrolled to the program.

(4) ENTRY INTO CASE MANAGEMENT.

(a) The county of origin must enter an individual who is eligible for developmental disabilities services into case management services.

(b) Upon entry into case management services, the CME must provide an explanation of the individual rights described in OAR 411-318-0010 to the individual and if applicable the legal representative of the individual.

(c) The CME must assure the availability of a case manager to address the support needs of the individual and any emergency or crisis. The CME must appropriately document the assignment of the

case manager in the service record for the individual and the CME must accurately report entry into case management services in the Department payment and reporting systems.

(A) Within 10 business days from the date of entry, the CME must send a written notice to the individual, and as applicable the legal representative of the individual, that includes the name, telephone number, and location of the case manager assigned to the individual.

(B) The CME must ask the individual, and as applicable the legal representative of the individual, to identify any family and other advocates to whom the CME must provide the name, telephone number, and location of the case manager.

(5) EXIT FROM CASE MANAGEMENT.

(a) A CME retains responsibility for providing case management services to an individual until the responsibility is terminated and the individual exits from case management services as described in this rule.

(b) A CME must exit an individual from case management services when any of the following occur:

(A) The individual, or as applicable the legal representative of the individual, submits a signed written request terminating case management services, or such a request is made by telephone and documented in the service record for the individual.

(B) The individual dies.

(C) The individual is determined to be ineligible for --

(i) Developmental disabilities services in accordance with OAR 411-320-0080; or

(ii) CIIS in accordance with OAR chapter 411, division 300.

(D) The individual moves out of Oregon.

(E) The individual moves out of the geographic service area of the CME. If an individual takes up residence in another geographic service area, a CME that operates in the new geographic service area may enter the individual into case management services.

(i) If an individual receiving case management from a CDDP moves to a new geographic service area, the original CDDP may continue to provide case management services to the individual. The individual, or as applicable the legal or designated representative of the individual, must request to retain case management services from the original CDDP, and both the original CDDP and the CDDP in the new location must agree in writing to the responsibilities for delivering case management services.

(ii) If an adult individual receiving case management from a Brokerage moves to a new geographic service area, the Brokerage may continue to provide case management services. The adult individual, or as applicable the legal or designated representative of the individual, must request to retain case management services from the original Brokerage, and the Department must approve. Approval may be granted if the Brokerage is available to meet the case management standards described in OAR 411-415-0050 timely and adequately and the Brokerage has the capacity to deliver the case management services.

(iii) In the case of a child moving into a foster home or 24-hour residential program, the county of parental residency or court jurisdiction must retain responsibility for case management services unless --

(I) The child is entering into a state operated group home; or

(II) An agreement between the CDDPs and the legal representative of the child is reached that describes the responsibilities for case management services.

(F) After the individual either cannot be located or has not responded after a minimum of 30 days of repeated attempts by CME staff to complete ISP development, annual plan development, or monitoring activities, including participation in a functional needs assessment.

(c) An exit from case management services is an exit from all developmental disabilities services, except in the case of a move by an individual within the state, but out of the geographic service area of the CME.

(d) When an individual is being exited from case management services, the CME must issue a Notification of Planned Action consistent with OAR 411-318-0020 to notify the individual, and as applicable the legal representative of the individual, of the intent of the CME to terminate case management services and any other developmental disabilities services. A Notification of Planned Action is not required when the exit from case management is due to:

(A) The death of the individual; or

(B) A move by the individual within the state, but out of the geographic service area of the CME.

(e) When a child is exited from a CIIS program, the child may be entered into a CDDP for case management services if the child is eligible for developmental disabilities services according to OAR 411-320-0080.

(6) CHANGE OF CASE MANAGEMENT SERVICES PROVIDER.

(a) An available CME, chosen by the individual, or as applicable the legal or designated representative of the individual, must enter an eligible individual into the CME within 10 days of a request to change the CME unless a later date is mutually agreed upon by the individual, or as applicable the legal or designated representative of

the individual, and the CMEs involved in the change. The agreement must be documented in the service record by the CME of the individual at the time of the agreement.

(b) A change in CME may only be to a CDDP or Brokerage that is within the same geographic service area as the residence of the individual, unless an exception is approved by the Department.

(c) The exiting CME must assure all relevant information is provided to the entering CME to assist the entering CME in implementing an ISP or Annual Plan that best meets the support needs of the individual, including, but not limited to:

(A) A current application on the Department-mandated application;

(B) A copy of the level of care determination, if present;

(C) A copy of the current functional needs assessment, if present;

(D) A copy of the eligibility determination;

(E) Copies of financial eligibility information;

(F) Copies of any legal documents, such as guardianship papers, conservatorship, civil commitment status, probation, and parole;

(G) Copies of progress notes; and

(H) A copy of the current ISP or Annual Plan, and any protocols, provider service agreements, behavior support, and nursing plans.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695

411-415-0040 Case Manager Staff Requirements

(Adopted 06/29/2016)

(1) CASE MANAGER. The case manager must have knowledge of the public service system for developmental disabilities services in Oregon and at least:

(a) A bachelor's degree in behavioral science, social science, or a closely related field;

(b) A bachelor’s degree in any field and one year of human services related experience, such as work providing assistance to people and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing;

(c) An associate’s degree in a behavioral science, social science, or a closely related field and two years of human services related experience, such as work providing assistance to people and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing; or

(d) Three years of human services related experience, such as work providing assistance to people and groups with issues, such as economical disadvantages, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, or housing.

(2) CASE MANAGER TRAINING. The case manager must participate in a core competency training sequence approved by the Department. The core competency training sequence is not a substitute for the normal procedural orientation that must be provided by the CME to the new case manager.

(a) The orientation provided by the CME to a new case manager must include:

(A) An overview of the role and responsibilities of a case manager.

(B) An overview of developmental disabilities services and related human services within the geographic service area of the CME.

(C) An overview of the Department's rules governing the CME.

(D) An overview of the Department's administrative rules, policies, and expenditure guidelines for services and service providers that may be authorized by the CME.

(E) An overview of the enrollment process and required documents needed for enrollment into the Department's payment and reporting systems.

(F) A review and orientation of Medicaid, SSI, Social Security Administration, home and community-based waiver and state plan services, OHP, and the individual support planning processes for the services they coordinate.

(G) A review (prior to having contact with individuals) of the case manager’s responsibility as a mandatory reporter of abuse, including abuse of individuals with intellectual or developmental disabilities, individuals with mental illness, older adults, individuals with physical disabilities, and children.

(b) The case manager must participate in an on-line series of required case management core competency modules as follows:

(A) A case manager hired after the adoption of these rules must complete:

(i) Tier 1 trainings within 30 days of the employment start date and before working unassisted.

(ii) Tier 2 trainings within 90 days of the employment start date.

(B) Other case managers must complete core competency modules as directed by the Department.

(c) Within the first year, the case manager must attend or participate in ISP training that is endorsed or sponsored by the Department.

(d) The case manager must continue to enhance his or her knowledge, as well as maintain a basic understanding of developmental disabilities services, self-determination, person-centered thinking and practices, and the skills, knowledge, and responsibilities necessary to perform the duties of the position. Each case manager must participate in a minimum of 20 hours per year of Department sponsored training or other training in the areas of intellectual or developmental disabilities.

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Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695

411-415-0050 Standards for Case Management Services
(Adopted 06/29/2016)

(1) The CME must apply the principles of self-determination and person-centered practices to provision of case management services.

(2) The CME must ensure that a case manager is available to provide case management services and other supports to the individual.

(a) Case management services include the activities related to:

(A) Assessment and periodic reassessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services including those assessments described in OAR 411-415-0060.

(B) Development and periodic revision of an ISP or Annual Plan based on the information collected through an assessment or reassessment that specifies the desired outcomes, goals, and actions to address the medical, employment, social, educational, and other services needed by the eligible individual as described in OAR 411-415-0070.

(C) Accessing available services, including referral and related activities to help an individual obtain needed services as described in OAR 411-415-0080.

(D) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the ISP or Annual Plan is effectively implemented and adequately addresses the needs of the eligible individual as described in OAR 411-415-0090.

(b) Other supports provided by a CME may include, but are not limited to:

(A) Authorizing services in the Department's electronic payments and reporting system;

(B) Arranging employer-related supports that may include, but are not limited to:

(i) Education about employer responsibilities;

(ii) Orientation to basic wage and hour issues; and

(iii) Use of common employer-related tools, such as service agreements.

(C) Assisting the Department with establishing provider credentials; and

(D) Assistance with understanding and accessing financial, medical, and other benefits.

(3) At least annually and at the request of the individual, or as applicable the legal representative of the individual, the CME must provide an explanation of the individual rights described in OAR 411-318-0010 to the individual and if applicable the legal representative of the individual.

(4) A CME may not authorize services that are delivered by an affiliated entity.

(5) Developmental disabilities services must be authorized in accordance with OAR 411-415-0070. A case manager must authorize any developmental disabilities service chosen by the individual, or as applicable the legal or designated representative of the individual, for which the individual is eligible as described in the relevant program rules.

(a) NOTIFICATION OF PLANNED ACTION. In the event that a developmental disabilities service is denied, reduced, suspended, or terminated, a written advance Notification of Planned Action (form SDS 0947) must be provided as described in OAR 411-318-0020.

(b) HEARINGS.

(A) Hearings must be addressed in accordance with ORS chapter 183 and OAR 411-318-0025.

(B) An individual may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025.

(c) Upon entry into case management, upon request, and annually thereafter, a notice of hearing rights and the policy and procedures for hearings as described in OAR chapter 411, division 318 must be explained and provided to an individual, and as applicable the legal or designated representative of the individual.

(6) Services authorized in an ISP must be entered into the Department's payment and reporting system within 30 days of the start of the services being delivered by any individual provider.

(7) If an individual loses eligibility for a Medicaid Title XIX (OHP) Benefit Package, a case manager must assist the individual to identify why the eligibility was lost. Whenever possible, the case manager must assist the individual in reestablishing the eligibility. The case manager must document the assistance given in the service record for the individual.

(8) A case manager must participate in the delivery of protective services for adults and children when required by Oregon Administrative Rule or Oregon Revised Statute.

(9) CHOICE ADVISING. Through choice advising, the CME must assure that case management and other developmental disabilities service options, provider options, and setting options, including non-disability specific settings and an option for a private or shared unit in a residential program, are described to all individuals receiving case management services from the CME, or to the legal representative of the individual.

(a) An individual newly determined eligible for developmental disabilities services must receive choice advising prior to or concurrent with the initial level of care determination.

(b) Choice advising occurs as part of the person-centered planning process and must be conducted prior to an initial ISP and prior to a review of the ISP when required according to OAR 411-415-0070(3).

(c) Choice advising must occur at least six months before the18th birthday of a child.

(d) If a CME is affiliated with an agency provider of developmental disabilities services in addition to case management services, the CME must disclose the relationship and inform the individual, or as applicable the legal or designated representative of the individual, that the CME cannot authorize the affiliated provider. The CME must discuss other case management provider options when the individual, or as applicable the legal or designated representative of the individual, expresses interest in receiving services from the affiliated provider.

(10) A case manager must coordinate services with the child welfare caseworker assigned to a child to ensure the provision of required supports from the Department, CDDP, and child welfare.

(11) The case manager must participate in transition planning by attending IEP meetings or other transition planning meetings for students 16 years of age or older to discuss the transition of the student to adult living and work situations, unless the attendance of the case manager is refused by the parent or guardian of the student or the student if the student is 18 years or older. The case manager must participate in transition planning as young as age 14, if transition planning deemed appropriate by the student's IEP

team, unless the attendance of the case manager is refused by the parent or guardian of the student or the student if the student is 18 years or older.

(12) When appropriate, a case manager must coordinate with vocational rehabilitation regarding employment services. When appropriate, a case manager must facilitate referrals to vocational rehabilitation.

(13) A services coordinator at a CDDP must ensure that all serious events related to an individual are reported to the Department using the SERT system. The CDDP must ensure that there is monitoring and follow-up on both individual events and system trends.

(14) A services coordinator at a CDDP must participate in the appointment of the health care representative of an individual as described in OAR chapter 411, division 365.

(15) The CME must implement procedures to address individual, designated representative, or family complaints regarding service delivery that have not been resolved using the complaint procedures (informal or formal) of a provider agency. The complaint procedures must be consistent with the requirements in OAR 411-318-0015.

(16) A case manager must coordinate with other state, public, and private agencies regarding services to individuals.

(17) When appropriate, a case manager must facilitate referrals to nursing facilities as described in OAR 411-070-0043.

(18) A case manager must coordinate and monitor the services provided to an eligible individual living in a nursing facility.

(19) A Department case manager must make referrals for entry and participate in all entry meetings for children in residential programs, CIIS, and the Stabilization and Crisis Unit.

(20) The CME must provide case management services to individuals who are eligible for and desire them. If an individual receiving case management services from a CDDP is receiving other developmental disabilities services in more than one county, the county of origin must be

responsible for case management services unless otherwise negotiated and documented in writing with the mutually agreed upon conditions.

(21) CHANGE OF CASE MANAGER.

(a) If the CME changes the assignment of a case manager for any reason, the CME must notify the individual, the legal and designated representative of the individual (as applicable), and all providers within 10 business days of the change. The notification must be in writing and include the name, telephone number, email address, and mailing address of the new case manager.

(b) The individual receiving services, or as applicable the legal or designated representative of the individual, may request a new case manager within the same CME or request a change of case management entity.

(22) FAMILY RECONNECTION. The CME and a case manager must provide assistance to the Department when a family member is attempting to reconnect with an individual who was previously discharged from Fairview Training Center or Eastern Oregon Training Center or an individual who is currently receiving developmental disabilities services.

(a) If a family member contacts the CME for assistance in locating an individual, the CME must refer the family member to the Department. A family member may contact the Department directly.

(b) The Department shall send the family member a Department form requesting further information to be used in providing notification to the individual. The form shall include the following information:

(A) Name of requestor;

(B) Address of requestor and other contact information;

(C) Relationship to individual;

(D) Reason for wanting to reconnect; and

(E) Last time the family had contact.

(c) The Department shall determine:

(A) If the individual was previously a resident of Fairview Training Center or Eastern Oregon Training Center;

(B) If the individual is deceased or living;

(C) Whether the individual is currently or previously enrolled in Department services; and

(D) The county in which services are being provided, if applicable.

(d) With permission from the individual, the Department shall notify the family member if the individual is enrolled or no longer enrolled in Department services within 10 business days from the receipt of the request.

(e) If the individual is enrolled in Department services, the Department shall send the completed family information form to the individual and the case manager.

(f) If the individual is deceased, the Department shall follow the process for identifying the personal representative of the individual as provided for in ORS 192.526.

(A) If the personal representative and the requesting family member are the same, the Department shall inform the personal representative that the individual is deceased.

(B) If the personal representative is different from the requesting family member, the Department shall contact the personal representative for permission before sharing information about the individual with the requesting family member. The Department must make a good faith effort to find the personal representative and obtain a decision concerning the sharing of information as soon as practicable.

(g) When an individual is located, the CME must facilitate a meeting with the individual to discuss and determine if the individual wishes to have contact with the family member.

(A) The case manager must assist the individual in evaluating the information to make a decision regarding initiating contact, including providing the information from the form and any relevant history with the family member that may support contact or present a risk to the individual.

(B) If the individual does not have a legal representative or is unable to express his or her wishes, the ISP team of the individual must be convened to review factors and choose the best response for the individual after evaluating the situation.

(h) If the individual wishes to have contact, the individual or ISP team designee may directly contact the family member to make arrangements for the contact.

(i) If the individual does not wish to have contact, the CME must notify the Department. The Department shall inform the family member in writing that no contact is requested.

(j) The notification to the family member regarding the decision of the individual must be within 60 business days from the receipt of the information form from the family member.

(k) The decision by the individual is not appealable.

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411-415-0060 Assessment and Reassessment Activities
(Temporary Effective 09/01/2016 to 02/27/2017)

(1) LEVEL OF CARE DETERMINATION.

(a) A case manager must assure that an individual has an initial level of care determination prior to accessing Community First Choice

state plan or waiver services. The level of care determination must be made using a Department prescribed form based on a face to face contact. An initial level of care determination must be submitted to the Department within 30 days of the date the individual or their legal representative signed the completed level of care determination.

(b) A case manager must assure that a level of care determination is reviewed for every individual receiving Community First Choice state plan or waiver services --

(A) Within 12 months from the previous annual review.

(i) The first annual review must be completed no later than 12 months from the date of the approval of the Diagnosis and Evaluation Coordinator (D & E Coordinator).

(ii) The annual review date may be reset for a date earlier than 12 months from the date of the approval of the D & E Coordinator, but no later than 12 months from the date of the review of the D & E Coordinator.

(B) No earlier than 60 days prior to the implementation of a renewed ISP.

(C) Any time there is a significant change in a condition that qualified the individual for the level of care.

(c) When a case manager completes an initial level of care determination, the case manager must ensure that an individual enrolled to a Medicaid Title XIX (OHP) Benefit Package is:

(A) Offered and advised of all services available for which the individual is eligible including, but not limited to, the choice of institutional or home and community-based services.

(B) Provided a Notification of Rights (form APD 0948).

(d) The occasion of the level of care determination must be documented in a progress note in the service record for the

individual, including that the determination was made based on a face to face contact with the individual.

(2) FUNCTIONAL NEEDS ASSESSMENT. A case manager must assure a functional needs assessment is conducted initially and at least annually for each individual who has or is expected to have an ISP.

(a) The functional needs assessment must be completed:

(A) Within 45 days from the date that the individual submitted a completed application or the date the CME learns of the eligibility of the individual for a Medicaid Title XIX (OHP) Benefit Package;

(B) Prior to, but not more than 60 days prior to, the authorization of an initial ISP or the annual renewal of an ISP;

(C) Within 45 days from the date an individual, or as applicable their legal or designated representative, requests a new functional needs assessment; and

(D) Within 45 days from the date the CME acquires information that the support needs of an individual may have changed significantly enough to change the current service level as defined in OAR 411-450-0020.

(b) No fewer than 14 days prior to conducting a functional needs assessment, the CME must mail a notice of the assessment process to the individual to be assessed. The notice must include a description and explanation of the assessment process and an explanation of the process for appealing the results of the assessment.

(c) At the discretion of the Department, the Department may conduct or assign an alternate assessor to conduct the functional needs assessment in lieu of a case manager.

(d) The functional needs assessment must include a face to face contact with the individual by the case manager or alternate assessor.

(3) An assessment for State Plan Personal Care must be completed by a case manager as described in OAR 411-034-0070.

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411-415-0070 Service Planning
(Temporary Effective 09/01/2016 to 02/27/2017)

This rule prescribes standards for the development and implementation of an ISP or Annual Plan.

(1) An ISP must meet the following requirements:

(a) Be developed based on assessed need.

(b) For community living supports, be developed and based on assessed need and within the service level as defined in OAR 411-450-0020 and as determined by an ANA or CNA (as applicable).

(c) Be developed using a person-centered process consistent with OAR 411-004-0030(1) and in a manner that addresses issues of independence, integration, and provides opportunities to seek employment and work in competitive integrated employment settings, in order to assist with establishing outcomes, planning for supports, and reviewing and redesigning support strategies.

(d) Be designed to enhance the quality of the life of the individual.

(e) Be consistent with the following principles:

(A) Adult individuals have the right to make informed choices about the level of family member participation.

(B) The preferences of the individual and the family of a child must serve to guide the ISP team. The case manager must facilitate active participation of the individual throughout the planning process.

(C) The planning process is designed to identify the types of services and supports necessary to achieve the preferences of an individual and the family of a child, identify the barriers to providing those preferred services, and develop strategies for reducing the barriers.

(D) Specify cost-effective arrangements for obtaining the required supports and applying public, private, formal, and informal resources available to the eligible individual.

(E) When planning for a child in a 24-hour residential program or foster care, the following must apply:

(i) Unless contraindicated, there must be a goal for family reunification.

(ii) The number of moves or transfers must be kept to a minimum.

(iii) Unless contraindicated, if the placement of a child is distant from their family, the case manager must continue to seek a placement that brings the child closer to their family.

(2) An individual enrolled in waiver or Community First Choice state plan services must have an ISP, completed on a Department approved document, consistent with the outcome of the person centered planning process and OAR 411-004-0030(2).

(a) The initial ISP:

(A) May begin a transition period; and

(B) Must be authorized no more than 90 days from the date a completed application is submitted to the CDDP as described in OAR 411-320-0080.

(b) An initial ISP has a duration of 12 full months, beginning the month following the authorization of the ISP.

(c) The duration of an annual ISP may not exceed 12 months. With the consent of an individual, or as applicable their legal or designated representative, a new start date for an ISP may be established within the 12 months when the individual enters or exits any of the following:

(A) A 24-hour residential program as described in OAR chapter 411, division 325. A transfer to a new setting within the same 24-hour residential program may not cause a new start date for an ISP.

(B) A supported living program as described in OAR chapter 411, division 328. A transfer to a new setting within the same supported living program may not cause a new start date for an ISP.

(C) A foster home as described in OAR chapter 411, division 346 for children or OAR chapter 411, division 360 for adults.

(D) A CIIS program.

(d) During a transition period, the ISP must include the minimum necessary services and supports for an individual upon entry to a new program type, setting, or CME. The ISP during a transition period must include, at a minimum, an authorization of necessary services, the supports needed to facilitate adjustment to the services offered, the supports necessary to ensure health and safety, and the assessments and consultations necessary for further ISP development.

(e) All Department funded developmental disabilities services included in an ISP must be consistent with the ISP manual, Department policy, and the In-Home Expenditure Guidelines when applicable.

(f) For Community First Choice state plan and waiver services, the supports included in an ISP must address a need that has been determined to be necessary by a functional needs assessment and the identified goals and preferences of the individual.

(g) An initial or annual ISP authorized to begin on or after March 1, 2017 must include any individually-based limitations as described in OAR 411-004-0040. All individually-based limitations must be included in the ISP no later than February 28, 2018.

(3) CAREER DEVELOPMENT PLAN.

(a) A Career Development Plan must be completed as part of the ISP:

(A) When the individual is working-age; or

(B) Prior to the expected exit from school for students eligible for services under the Individuals with Disabilities Education Act (I.D.E.A.). If a student leaves school prior to the expected exit, the student must have the opportunity to have a Career Development Plan within one year of the unexpected exit.

(b) The Career Development Plan must meet the following requirements:

(A) For an individual who uses employment services under OAR chapter 411, division 345, include goals and objectives related to obtaining, maintaining, or advancing in competitive integrated employment, or, at minimum, exploring competitive integrated employment or developing skills that may be used in competitive integrated employment.

(B) Be developed based on a presumption that, with the right support and job match, the individual may succeed and advance in an integrated employment setting and earn minimum wage or better.

(C) Prioritize competitive integrated employment in the general workforce.

(D) For an individual who has competitive integrated employment, person-centered service planning must focus on maintaining employment, maximizing the number of hours an individual works consistent with their preferences and interests,

improving wages and benefits, and promoting additional career or advancement opportunities.

(E) For an individual using job coaching or job development services, the Career Development Plan must document either a goal or discussion regarding opportunities for maximizing work hours and other career advancement opportunities. The recommended standard for planning job coaching and job development is the opportunity to work at least 20 hours per week. Individualized planning should ultimately be based on individual choice, preferences, and circumstances, and recognize that an individual may choose to pursue working full time, part time, or another goal identified by the individual.

(F) Document all employment service options presented, including the option to use employment services in a non-disability specific setting, meaning a setting that is not owned, operated, or controlled by a provider of home and community-based services.

(G) For individuals who use employment services in sheltered workshop settings, the Career Development Plan must document that the individual has been encouraged to choose a community-based employment service option and not a sheltered workshop setting option.

(4) ISP REVIEWS.

(a) An ISP must be reviewed, revised, and re-authorized as needed:

(A) No more than 30 days following a functional needs assessment conducted pursuant to sections (2)(a)(C) or (D) of OAR 411-415-0060;

(B) Prior to the expiration of the ISP;

(C) No later than the end of a transition period;

(D) When the circumstances or needs of an individual change significantly; and

(E) At the request of an individual or as applicable their legal or designated representative.

(b) For an individual who changes CME, but remains in an in-home setting, the ISP authorized by the previous CME may be used as authorization for available services for the new CME for up to 60 days when the services in the new setting remain appropriate services.

(5) TEAM PROCESS IN PERSON-CENTERED PLANNING. This section applies to an ISP developed for an individual receiving services in a residential program:

(a) The ISP is developed by the individual, their legal or designated representative (as applicable), and the Services Coordinator. Others may be included as a part of the ISP team at the invitation of the individual and as applicable their legal or designated representative. In order to assure adequate planning, provider representatives are necessary informants to the ISP team even when not ISP team members.

(b) In circumstances where an individual is unable to express their opinion or choice using words, behaviors, or other means of communication and the individual does not have a legal or designated representative the following apply:

(A) The ISP team is empowered to make a decision on behalf of the individual the ISP team feels best meets the health, safety, and assessed needs of the individual.

(B) Consensus amongst ISP team members is prioritized. When consensus may not be reached, majority agreement is used. For purposes of reaching a majority agreement each interested party, which may be represented by more than one person, is considered as one member of the ISP team. Interested parties may include, but are not limited to, the provider, family, Services Coordinator, and designated representative.

(C) No one member of an ISP team has the authority to make decisions for the ISP team.

(c) Any objections to decisions of the ISP team by a member of the ISP team must be documented in the ISP.

(d) A Services Coordinator must track the ISP timelines and coordinate the resolution of complaints and conflicts arising from ISP discussions.

(6) ISP AUTHORIZATION.

(a) An initial and annual ISP must be authorized prior to implementation.

(b) A revision to an initial or annual ISP that involves the types of developmental disabilities services paid using Department funds must be authorized prior to implementation.

(c) A revision to an initial or annual ISP that does not involve the types of developmental disabilities services paid using Department funds does not require authorization. Documented agreement to the revision by the individual, or as applicable their legal or designated representative, is required prior to implementation of the revision.

(d) An initial ISP, and a revision to an initial or annual ISP requiring authorization, is authorized on the date --

(A) The signature of the individual, or as applicable their legal or designated representative, is present on the ISP or documentation is present explaining the reason an individual who does not have a legal or designated representative may be unable to sign the ISP.

(i) Acceptable reasons for an individual without a legal or designated representative not to sign the ISP include physical or behavioral inability to sign the ISP.

(ii) Unavailability is not an acceptable reason for an individual, or as applicable their legal or designated representative, not to sign the ISP.

(iii) In the case of a revision to an initial or annual ISP that is in response to immediate, unexpected change in circumstance, and is necessary to prevent injury or harm to the individual, documented oral agreement may substitute for a signature for up to 10 business days.

(B) The signature of the case manager involved in the development of, or revision to, the ISP is present on the ISP.

(e) A renewing ISP signed as described in this section is authorized to begin the first day after the previous ISP expired.

(f) After September 1, 2018, newly authorized developmental disabilities services may only be authorized to occur in a setting consistent with OAR 411-004-0020. By March 17, 2019, all authorized developmental disabilities services must occur in a setting consistent with OAR 411-004-0020.

(g) Community First Choice state plan and waiver services are only funded by the Department when the services are authorized on an ISP developed in a manner consistent with this rule.

(h) A legal or designated representative responsible for directing the development of the ISP on behalf of the individual (as applicable) may not be authorized to be a paid provider for the individual.

(i) An ISP must authorize the hours for personal support workers consistent with the payment limitations described in OAR 411-375-0040.

(j) The CME may not authorize a service provider, setting, or a combination of services selected by an eligible individual or the representative of the individual when --

(A) The setting has dangerous conditions that jeopardize the health or safety of the individual and necessary safeguards cannot be taken to improve the setting;

(B) Services cannot be provided safely or adequately by the service provider based on --

(i) The extent of the service needs of the individual; or

(ii) The choices or preferences of the eligible individual or as applicable their legal or designated representative.

(C) Dangerous conditions in the service setting jeopardize the health or safety of the service provider authorized and paid for by the Department, and necessary safeguards cannot be taken to minimize the dangers; or

(D) The individual does not have the ability to express their informed decision, does not have a designated representative to make decisions on their behalf, and the Department or CME cannot take necessary safeguards to protect the safety, health, and welfare of the individual.

(k) The case manager must present the individual, or as applicable their legal or designated representative, with information on service alternatives and provide assistance to assess other choices when the service provider or service setting selected by the individual, or as applicable their legal or designated representative, is not authorized.

(l) The ISP for an adult enrolled in foster care under OAR chapter 411, division 360, must include at least six hours of activities each week that are of interest to the individual that do not include television or movies made available by the provider. Activities are those available in the community and made available or offered by the provider or the CDDP.

(A) Activities may include:

(i) Recreational and leisure activities; and

(ii) Other activities required to meet the needs of an individual as described in the ISP for the individual.

(B) Activities that contribute to the six hours may not include:

(i) Rehabilitation;

(ii) Educational services; or

(iii) Employment services.

(m) Not more than two weeks after authorization, the CME must provide a copy of the most current ISP to the individual, their legal and designated representative (as applicable), and others as identified by the individual. The ISP must be made available using language, format, and presentation methods appropriate for effective communication according to the needs and abilities of the individual receiving services and the people important in supporting the individual. When an authorized ISP must be translated from English, translation must be initiated within two weeks of authorization and the translated document must be provided to the individual by the CME upon receipt.

(7) DEVELOPMENTAL DISABILITIES SERVICE AUTHORIZATIONS.

(a) Developmental disabilities services may not be authorized when:

(A) The individual does not meet the service eligibility requirements in the program rule corresponding to the service.

(B) The case manager is not permitted to conduct a monitoring visit to the home as required in OAR 411-415-0090(3)(d).

(b) A Services Coordinator employed by a CDDP, or a sub-contractor of a CDDP contracted to deliver case management, may authorize an eligible individual to receive the following developmental disabilities services:

(A) Community First Choice 1915(k) state plan services.

(B) Services described in the ICF/IDD Comprehensive 1915(c) waiver.

(C) State Plan Personal Care as described in OAR chapter 411, division 034.

(D) Home delivered meals as described in OAR chapter 411, division 40.

(E) Private duty nursing as described in OAR chapter 410, division 132 and OAR 411-300-0150.

(c) A Personal Agent may authorize an eligible individual to receive the following developmental disabilities services:

(A) Community First Choice 1915(k) state plan services, except services delivered as part of a residential program.

(B) Services described in the Support Services 1915(c) waiver.

(C) State Plan Personal Care as described in OAR chapter 411, division 034.

(D) Home delivered meals as described in OAR chapter 411, division 40.

(E) Private duty nursing as described in OAR chapter 410, division 132 and OAR 411-300-0150.

(d) A CIIS Services Coordinator may authorize an eligible individual to receive the following developmental disabilities services:

(A) Community First Choice 1915(k) state plan services.

(B) Services described in the following 1915(c) waivers:

(i) Medically Involved Children's Waiver;

(ii) Medically Fragile (Hospital) Model Waiver; and

(iii) Behavioral (ICF/IDD) Model Waiver.

(C) State Plan Personal Care as described in OAR chapter 411, division 034.

(D) Private duty nursing as described in OAR chapter 410, division 132 and OAR 411-300-0150.

(e) The Department authorizes entry for children into residential programs, CIIS, and the Stabilization and Crisis Unit.

(8) ANNUAL PLANS. Individuals enrolled in case management services, but not accessing Community First Choice state plan or waiver services must have an Annual Plan.

(a) A case manager must develop an Annual Plan within 90 days of the enrollment of an individual into case management services and annually thereafter if the individual is not enrolled in any Community First Choice state plan or waiver services.

(b) An Annual Plan must be developed as follows:

(A) For an adult, a written Annual Plan must be documented as an Annual Plan or as a comprehensive progress note in the service record for the individual and consist of the following:

(i) A review of the current living situation of the individual.

(ii) A review of the employment status of the individual and a summary of any related support needs.

(iii) A review of any personal health, safety, or behavioral concerns.

(iv) A summary of the support needs of the individual.

(v) Actions to be taken by the case manager and others.

(B) For a child receiving family support services, a Services Coordinator must coordinate with the child and their family or

guardian in the development of an Annual Plan. The Annual Plan for a child receiving family support services must be in accordance with OAR 411-305-0080.

(c) An Annual Plan must be kept current. A case manager must ensure that a current Annual Plan is maintained for each individual receiving services.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695

411-415-0080 Accessing Developmental Disabilities Services
(Adopted 06/29/2016)

(1) A CME is required to:

(a) Provide assistance in finding and arranging resources, services, and supports.

(b) Provide information and technical assistance to an individual, and as applicable the legal or designated representative of the individual, in order to make informed decisions. This may include, but is not limited to, information about support needs, settings, programs, and types of providers.

(c) Provide a brief description of the services available from the CME, including typical timelines for activities, required assessments, monitoring and other activities required for participation in a Medicaid program, and the planning process.

(d) Inform the individual, or as applicable the legal or designated representative of the individual, of any potential conflicts of interest between the CME and providers available to the individual.

(e) Inform providers of the responsibility:

(A) To carry out their duty as mandatory reporters of suspected abuse; and

(B) To immediately notify anyone specified by the individual of any incident that occurs when the provider is providing services when the incident may have a serious effect on the health, safety, physical, or emotional well-being, or level of services required.

(2) LICENSED OR CERTIFIED RESIDENTIAL PLACEMENT SETTING OPTIONS. In accordance with ORS 427.121, a case manager must present at least three appropriate licensed or certified residential setting options, including at least two different types of settings, to an adult individual eligible for and desiring to receive services in a licensed or certified residential setting, or to the legal representative, prior to the entry of the adult individual into a licensed or certified residential setting. The case manager is not required to present the licensed or certified residential placement setting options if:

(a) The case manager demonstrates that three appropriate licensed or certified residential placement settings or two different types of settings are not available within the geographic area where the individual wishes to reside;

(b) The individual selects a licensed or certified residential placement setting option and waives the right to be presented with other licensed or certified residential setting options; or

(c) The individual has an imminent risk to health or safety in the current licensed or certified residential setting.

(3) In accordance with the rules for home and community-based services in OAR chapter 411, division 004, an individual, or as applicable the legal or designated representative of the individual, must be advised regarding non-residential service options including employment services and non-residential community living supports. For services considered, a non-disability specific setting option must be presented and documented in the person-centered service plan.

(4) WRITTEN INFORMATION REQUIRED. A case manager must give the relevant content from the ISP that is necessary to for each provider to deliver the services the provider is authorized to deliver, prior to the start of services. The content must include the relevant risks identified in a risk

identification tool. The risks are relevant when they may reasonably be expected to threaten the health and safety of the individual, the provider, or the community at large without appropriate precautions during the delivery of the service authorized for the provider to deliver. If an individual, or as applicable the legal representative of the individual, refuses to disclose the information, the CME must disclose the refusal to the provider, who may choose to refuse to deliver the services.

(a) The necessary information is conveyed on a Department approved Service Agreement containing the required content.

(b) For agency operators of a residential program or employment program, the case manager must provide to the agency:

(A) A document indicating safety skills, including the ability of the individual to evacuate from a building when warned by a signal device and adjust water temperature for bathing and washing;

(B) A brief written history of any behavioral challenges, including supervision and support needs;

(C) A record of known communicable diseases and allergies;

(D) Copies of protocols, the risk tracking record or risk identification tool, and any support documentation (if applicable);

(E) Copies of documents relating to health care representation; and

(F) A copy of the most recent Behavior Support Plan and assessment, Nursing Service Plan, and mental health treatment plan (if applicable).

(c) In addition to sub-section (b) of this section, residential programs must be given:

(A) A copy of the eligibility determination document;

(B) A medical history and information on health care supports that includes (when available):

(i) The results of the most recent physical exam;

(ii) The results of any dental evaluation;

(iii) A record of immunizations;

(iv) A record of major illnesses and hospitalizations; and

(v) A written record of any current or recommended medications, treatments, diets, and aids to physical functioning.

(C) A copy of the most recent functional needs assessment. If the needs of an individual have changed over time, the previous functional needs assessments must also be provided;

(D) Copies of documents relating to the guardianship or conservatorship, power of attorney, court orders, probation and parole information, or any other legal restrictions on the rights of the individual (if applicable);

(E) Written documentation that the individual is participating in out-of-residence activities, including public school enrollment for individuals less than 21 years of age; and

(F) A copy of any completed and signed forms documenting consent to an individually-based limitation described in OAR 411-004-0040. The form must be signed by the individual, or, if applicable the legal representative of the individual.

(d) In addition to sub-section (b) of this section, agency providers of employment services must be given:

(A) The Career Development Plan.

(B) Protocols that are necessary to assure the health and safety of the individual.

(e) When an individual is known to be accessing Vocational Rehabilitation services, the Vocational Rehabilitation counselor must be given the Career Development Plan.

(f) If the individual is being entered into a residential program from the family home and the information required in subsection (b) and (c) of this section is not available, the case manager must ensure that the residential program provider assesses the individual upon entry for issues of immediate health or safety.

(A) The case manager must develop and document a plan to secure the information listed in subsection (a) of this section no later than 30 days after entry.

(B) The plan must include a written justification as to why the information is not available and a copy of the plan must be given to the provider at the time of entry.

(5) ENTRY MEETING. No later than the date of entry of an individual into a residential program, a case manager must convene a meeting of the ISP team to review referral material in order to determine appropriateness of entry. An entry meeting may be held for entry into services other than a residential program when a member of the ISP team requests one. A potential provider may request an entry meeting and may refuse entry to an individual who refuses to permit one. Findings of the entry meeting must be recorded in the service record for the individual and distributed to the ISP team members. The findings of the entry meeting must include, at a minimum:

(a) The name of the individual proposed for services.

(b) The date of the entry meeting.

(c) The date determined to be the date of entry.

(d) Documentation of the participants included in the entry meeting;

(e) Documentation of information required by section (4) of this rule when entering a residential program.

(f) Documentation of the decision to serve the individual requesting services.

(6) TRANSFER MEETING. A meeting of the ISP team must precede any transfer of an individual that was not initiated by the individual, or as applicable the legal representative of the individual, unless the individual declines to have a meeting. Findings of the transfer meeting must be recorded in the service record for the individual and include, at a minimum:

(a) The name of the individual considered for transfer.

(b) The date of the transfer meeting.

(c) Documentation of the participants included in the transfer meeting.

(d) Documentation of the circumstances leading to the proposed transfer.

(e) Documentation of the alternatives considered instead of transfer.

(f) Documentation of the reasons any preferences of the individual, or as applicable the legal or designated representative or family members of the individual, may not be honored.

(g) Documentation of the decision regarding the transfer, including verification of the voluntary decision to transfer or a copy of the Notice of Involuntary Reduction, Transfer, or Exit.

(h) The written plan for services for the individual after transfer.

(7) EXIT MEETING. A case manager must offer the individual, and legal or designated representative, an opportunity to convene the ISP team prior to an exit of an individual from a residential program or from agency provided employment services. Findings of the exit meeting must be recorded in the service record for the individual and include, at a minimum:

(a) The name of the individual considered for exit.

(b) The date of the exit meeting.

(c) Documentation of the participants included in the exit meeting.

(d) Documentation of the circumstances leading to the proposed exit.

(e) Documentation of the discussion of the strategies to prevent the exit of the individual from services, unless the individual or legal representative is requesting the exit.

(f) Documentation of the decision regarding the exit of the individual, including verification of the voluntary decision to exit or a copy of the Notice of Involuntary, Reduction, Transfer, or Exit.

(g) The written plan for services for the individual after the exit.

(h) Requirements for an exit meeting may be waived if an individual is immediately removed from the applicable program under the following conditions:

(A) The individual or legal representative requests an immediate exit from the program; or

(B) The individual is removed by legal authority acting pursuant to civil or criminal proceedings other than detention for an individual less than 18 years of age.

(8) When services are provided by an independent provider:

(a) The case manager must provide the individual, and as applicable the designated representative of the individual, a brief description of the responsibilities for use of public funds.

(b) Using a Department approved service agreement, the CME must inform an independent provider engaged to provide supports of:

(A) The type and amount of services authorized in the ISP for the independent provider to deliver; and

(B) Behavioral, medical, known risks, and other information about the individual that is required for the provider to safely and adequately deliver services to the individual.

(c) When an individual or designated representative chooses to receive services from an independent provider, the CME must assure that a person is identified to act as a common law employer for the independent provider consistent with OAR 411-375-0055.

(A) The CME may require intervention as defined in OAR 411-375-0055.

(B) The CME may deny a request for an employer representative if the requested employer representative has:

(i) A history of substantiated abuse or neglect of an adult as described in OAR 407-045-0250 to 407-045-0370;

(ii) A history of founded abuse or neglect of a child as described in OAR 413-015-1000;

(iii) Participated in billing excessive or fraudulent charges; or

(iv) Failed to meet the employer responsibilities described in OAR 411-375-0055, including previous termination as a result of failing to meet the employer.

(C) The CME shall mail a notice informing the individual, and as applicable the legal or designated representative of the individual, when:

(i) The CME denies, suspends, or terminates an employer from performing the employer responsibilities described in 411-375-0055; and

(ii) The CME denies, suspends, or terminates an employer representative from performing the employer responsibilities because the employer representative

does not meet the qualifications of an employer representative.

(D) If an individual, or as applicable the legal or designated representative or employer representative of the individual, is dissatisfied with the decision of the CME, the individual, or as applicable the legal or designated representative or employer representative of the individual, may request an administrator review by the Department as described in OAR 411-375-0070.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695

411-415-0090 Case Management Contact and Monitoring of Services
(Adopted 06/29/2016)

(1) CASE MANAGEMENT CONTACT. Every individual who has an ISP must have a case management contact no less than once every three months. Individuals with three or more significant health and safety risks as identified in the Risk Identification Tool, or if determined to be necessary by the case manager, must have monthly case management contact. At least one case management contact per year must be face to face. If an individual or legal representative agrees, other case management contact may be made by telephone or by other interactive methods. The outcome of the case management contact must be recorded in the progress notes. The purpose of the case management contact is:

(a) To assure known health and safety risks are adequately addressed;

(b) To assure that the support needs of an individual have not significantly changed; and

(c) To assure that an individual and designated representative is satisfied with the current supports.

(2) MONITORING OF SERVICES: A case manager must conduct monitoring activities using the framework described in this section.

(a) A case manager is required to provide assistance to the individual or the legal or designated representative with monitoring and improving the quality of supports.

(b) For all individuals with an ISP that authorizes waiver or Community First Choice state plan services, monitoring must include an assessment of the following:

(A) Are services being provided as described in the ISP and do the services result in the achievement of the identified action plans?

(B) Are the personal, civil, and legal rights of the individual protected in accordance with OAR chapter 411, division 318?

(C) Are the personal desires of the individual, and as applicable the legal or designated representative or family of the individual, addressed?

(D) Do the services authorized in the ISP continue to meet the assessed needs of the individual and what is important to, and for, the individual?

(E) Do identified desired outcomes and associated goals and action plans remain relevant and are the goals supported and being met?

(F) Are technological and adaptive equipment and environmental modifications being maintained and used as intended?

(G) Have changing needs or availability of other resources altered the need for continued use of Department funds to purchase supports?

(H) Are the services delivered in a setting that is in compliance with OAR 411-004-0020(1)?

(c) For an individual receiving employment services, the case manager must:

(A) Assess the progress of the individual toward competitive integrated employment; and

(B) When an individual is receiving facility based employment path services, visit each setting at least twice per plan year, while the individual is present, to verify and document the progress being made to support the individual to achieve employment goals documented in the Career Development Plan. Visits must occur no less than once every six months.

(d) When an individual or legal representative has consented to an individually-based limitation, service monitoring must include an evaluation of the ongoing need for the limitation.

(e) Unless specified in these rules, the minimum frequency of service monitoring must be determined by the needs of an individual.

(f) For an individual receiving only case management services and not enrolled in any other funded developmental disabilities services, the case manager must make contact with the individual at least once annually.

(A) Whenever possible, annual contact must be made in person. If annual contact is not made in person, a progress note in the service record must document how contact was achieved.

(B) If the individual has any identified high-risk medical issue including, but not limited to, risk of death due to aspiration, seizures, constipation, dehydration, diabetes, or significant behavioral issues, the case manager must maintain contact in accordance with planned actions as described in the Annual Plan.

(g) For an individual who is enrolled in a residential program the monitoring of services may be combined with the site visits described in section (3) of this rule. In addition:

(A) During a one year period, the services coordinator must review, at least once, services specific to health, safety, and behavior, using questions established by the Department.

(B) A semi-annual review of the process by which an individual accesses and utilizes funds must occur, using questions established by the Department. The services coordinator must determine whether financial records, bank statements, and personal spending funds are correctly reconciled and accounted for.

(i) The financial review standards for 24-hour residential programs are described in OAR 411-325-0380.

(ii) The financial review standards for adult foster homes are described in OAR 411-360-0170.

(iii) Any misuse of funds must be reported to the CDDP and the Department. The Department determines whether a referral to the Medicaid Fraud Control Unit is warranted.

(C) The services coordinator must monitor reports of serious and unusual incidents.

(h) If state plan personal care services as described in OAR 411-034-0070 are authorized in an Annual Plan, the services must be monitored as described in OAR 411-034-0070.

(3) SITE VISITS.

(a) The CDDP must ensure that quarterly site visits are conducted at each child or adult foster home and each 24-hour residential program setting licensed by the Department to serve individuals with intellectual or developmental disabilities.

(b) The CDDP must establish an annual schedule for site visits to each site that is owned, operated or controlled by:

(A) An employment program certified and endorsed under OAR chapter 411, division 345; and

(B) A community living supports program certified and endorsed under OAR chapter 411, division 450.

(c) The CDDP must conduct at least one visit annually to the home of an individual receiving services in a supported living setting.

(d) The CME must conduct at least one visit annually to the home of an individual receiving services in the home.

(e) Site visits may be increased for any of the following reasons including, but not limited to:

(A) Increased certified and licensed capacity;

(B) New individuals receiving services;

(C) Newly licensed or certified and endorsed provider;

(D) An abuse investigation;

(E) A serious event;

(F) A change in the management or staff of the licensed site or certified and endorsed program operator;

(G) An ISP team request; or

(H) Significant change in the functioning of an individual who receives services at the site.

(f) The CME must develop a procedure for the conduct of the site visits.

(g) The CME must document site visits and provide information concerning the site visits to the Department upon request.

(h) If there are no Department-funded individuals at the site, a visit by the CME is not required.

(i) When a provider is a Department-contracted and licensed, certified, and endorsed 24-hour residential program for children and the children's residential services coordinator for the Department is assigned to monitor services, the children's residential services coordinator and the CDDP shall coordinate the site visit. If the site visit is made by Department staff, Department staff shall provide the results of the site visit to the local services coordinator.

(j) The Department may conduct site visits on a more frequent basis than described in this section based on program needs.

(4) MONITORING FOLLOW-UP. A case manager and the CME are responsible for ensuring the appropriate follow-up to monitoring of services, except in the instance of children in 24-hour residential programs directly contracted with the Department when the Department conducts the follow-up.

(a) If the case manager determines that developmental disabilities services are not being delivered as agreed in the ISP for an individual, or that the service needs of an individual have changed since the last review, the case manager must initiate at least one of the following actions:

(A) Update the ISP of the individual.

(B) To remediate service delivery shortcomings, provide or refer technical assistance to an agency provider or common law employer for a personal support worker.

(b) If there are concerns regarding the ability of a provider to provide services, the CME must determine the need for technical assistance or other follow-up activities, such as coordination or provision of technical assistance, referral to the CDDP manager or brokerage director for consultation or corrective action, requesting assistance from the Department for licensing or other administrative support, or meeting with the executive director or board of directors of the provider.

(5) DEPARTMENT NOTIFICATION. The CME must notify the Department when:

(a) A provider demonstrates substantial failure to comply with any applicable licensing, certification, or endorsement rules for Department-funded programs.

(b) A personal support worker may have met any of the conditions identified in OAR 411-375-0070 that would cause the Department to inactivate or terminate the provider enrollment of the worker.

(c) The CME finds a serious and current threat endangering the health, safety, or welfare of individuals in a program for which an immediate action by the Department is required.

(d) Any individual receiving Department-funded developmental disabilities services dies. Notification must be made within one business day of the death. Entry must be made into the Serious Event Review System according to Department guidelines.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695

411-415-0100 Specialized Services in a Nursing Facility
(Adopted 06/29/2016)

An individual residing in a nursing facility determined to require specialized services, as described in OAR 411-070-0043, must have an annual plan for specialized services incorporated with a plan of care by the nursing facility.

(1) A case manager must coordinate with the individual, the legal representative of the individual, the staff of the nursing facility, and other service providers, as appropriate, to provide or arrange the specialized services. The plan for specialized services must include:

(a) The name of the service provider.

(b) A description of the specialized services to be provided.

(c) The number of hours of service per month.

(d) A description of how the services must be tracked.

(e) A description of the process of communication between the specialized service provider and the nursing facility in the event of unusual incidents, illness, absence, and emergencies.

(2) A case manager must complete an annual review of the plan for specialized services or when there has been a significant change in the level of functioning of the individual.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695

411-415-0110 Records Requirements
(Adopted 06/29/2016)

(1) In order to meet Department and federal record documentation requirements, the CME through the employees of the CME, must maintain a service record for each individual who receives services from the CME. The service record must include:

(a) Documentation of the functional needs assessment defining the support needs for ADL, IADL, and other health-related tasks.

(b) Documentation of choice advising.

(c) Documentation that the individual is eligible for any service authorized in an ISP.

(d) Referral information or documentation of referral materials sent to a provider or another CME.

(e) Progress notes written by a case manager as described in section (2) of this rule.

(f) The findings from service monitoring.

(g) Medical information, as appropriate.

(h) Entry and exit meeting documentation related to residential programs, including plans developed as a result of the meeting.

(i) Current and previous ISP or Annual Plan, including support documents and documentation that the plan is authorized by a case manager.

(j) A Nursing Service Plan must be present when Department funds are used to purchase services requiring the education and training of a licensed professional nurse.

(k) Copies of any incident reports initiated by a CME representative for any unusual incident that occurred at the CME or in the presence of the CME representative.

(l) Documentation of a review of unusual incidents received from providers. Documentation of the review of unusual incidents must be made in progress notes and a copy of the incident report must be maintained by the CME.

(m) Documentation of Medicaid eligibility, if applicable.

(n) The initial and annual level of care determination on a form prescribed by the Department.

> (A) For individuals receiving CIIS or services in a 24-hour residential program for children, the CDDP must maintain a current copy of the annual level of care determination or reflect documentation of attempts to obtain a current copy.
>
> (B) Once an individual is enrolled in a Brokerage, the CDDP must maintain a copy of the initial level of care determination form completed by the CDDP.

(o) Legal records, such as guardianship papers, civil commitment records, court orders, and probation and parole information (as appropriate).

(p) A case manager must maintain documentation of the referral process of an individual to a provider and if applicable, include the

reason the provider preferred by the individual declined to deliver services to the individual.

(q) An information sheet or reasonable alternative must be kept current and reviewed at least annually for each individual receiving case management services. Information must include:

(A) The name of the individual, current address, date of entry into the CME, date of birth, gender, marital status (for individuals 18 or older), religious preference, preferred hospital, medical prime number and private insurance number (where applicable), and guardianship status; and

(B) The name, address, and telephone number of:

(i) For an adult, the legal or designated representative, family, and other significant person of the individual (as applicable), and for a child, the parent or guardian and education surrogate (if applicable);

(ii) The primary care provider and clinic preferred by the individual;

(iii) The dentist preferred by the individual;

(iv) The school, day program, or employer of the individual (if applicable);

(v) Other agency representatives providing services to the individual; and

(vi) Any court ordered or legal representative authorized contacts or limitations from contact for individuals living in a foster home, supported living program, or 24-hour residential program.

(2) PROGRESS NOTES. Progress notes must include documentation of the delivery of case management services provided to an individual by a case manager. Progress notes must be recorded chronologically in the order they are made and documented consistent with CME policies and

procedures. All late entries must be appropriately noted as such. At a minimum, progress notes must include:

(a) The month, day, and year the services were rendered and the month, day, and year the entry was made if different from the date services were rendered;

(b) The name of the individual receiving service;

(c) The name of the CME, the person providing the services (i.e., the signature and title of the case manager), and the date the entry was recorded and signed;

(d) The nature and content of the case management services delivered and whether goals specified in the service plan have been achieved;

(e) Place of service. Place of service means the county where the CME or agency providing case management services is located, including the main address. The place of service may be a standard heading on each page of the progress notes; and

(f) For notes pertaining to meetings with or discussions about the individual, the names of other participants, including the titles and agency representation of the participants, if any.

(3) For individuals living in their own or family home, the CME must maintain a minimum acceptable record of expenditures for at least three years that includes:

(a) Itemized invoices and receipts to record the purchase of any single item.

(b) A trip log indicating purpose, date, and total miles to verify vehicle mileage reimbursement.

(c) Pay records to record employee services, including timesheets signed by both employee and employer.

(d) Itemized invoices for any services purchased from independent contractors, provider agencies, and professionals. Itemized invoices must include:

(A) The name of the individual to whom services were provided;

(B) The date of the services;

(C) The amount of services; and

(D) A description of the services.

(e) Evidence confirming the receipt, and securing the use of, assistive devices, environmental safety modifications, and environmental modifications.

(A) When an assistive device is obtained for the exclusive use of an individual, the CME must record the purpose, final cost, and date of receipt.

(B) The CME must secure use of equipment or furnishings costing more than $500 through a written agreement between the CME and the individual or the legal representative of the individual that specifies the time period the item is to be available to the individual and the responsibilities of all parties if the item is lost, damaged, or sold within that time period.

(4) Verification that providers meet the requirements to deliver services they are authorized to deliver including:

(a) Verification of a valid license to drive for any personal support worker, and proof of current auto insurance for the vehicle used for transportation, upon authorization of community transportation services.

(b) Documentation supporting the rate paid to a provider when it is above the minimum described in rule, policy, In-Home Expenditure Guidelines, or the base rate for a personal support worker identified in the current Collective Bargaining Agreement, including support for an enhanced and an exceptional personal support worker rate.

(5) Failure to furnish written documentation upon the written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, Centers for Medicare and Medicaid Services, or their authorized representatives, immediately or within timeframes specified in the written request, may be deemed reason to recover payments or deny further assistance.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695

411-415-0120 Reimbursement for Case Management Services
(Adopted 06/29/2016)

A CME is reimbursed for case management activities. Reimbursement may only be made when:

(1) The claim for reimbursement is for a service provided to an individual determined eligible for case management services.

(2) The individual providing the service is a qualified case manager as described in OAR 411-415-0040.

(3) An individual is properly enrolled into the Department's payment system.

(4) A claim has been made in the Department's payment system.

(5) Case management has been authorized on an ISP or as part of an Annual Plan.

(6) The claim is for a qualifying case management service.

(7) A progress note is in the individual file supporting the delivery of a case management service.

Stat. Auth.: ORS 409.050, 427.104, 427.154, 430.662
Stats. Implemented: ORS 427.005, 427.007, 427.101, 427.154-427.163, 430.212, 430.610, 430.620, 430.662-430.695