# Behavior Health Services Administrative Rulebook

## Chapter 410, Division 172

Effective November 26, 2019

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Behavior Health Services Rules

410-172-0600 – Acronyms and Definitions

(1) “ASAM PPC” means the most current publication of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-related Disorders, which is a clinical guide used in matching individuals to appropriate levels of care.

(2) “Behavioral Health” means mental health, mental illness, addiction disorders, and substance use disorders.

(3) “Behavioral Health Services” means medically appropriate services rendered or made available to a recipient for treatment of a behavioral health or substance use disorders diagnosis.

(4) “Community Mental Health Program (CMHP)” means an entity that is responsible for planning and delivery of services for persons with substance use disorders or a mental health diagnosis, operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Division as defined in OAR 309-019-0105.

(5) “Letter” means the document awarded to providers by AMH indicating the provider has complied with specific program requirements or administrative rule.

(6) “Level of Care” means the type, frequency, and duration of medically appropriate services provided to a recipient of behavioral health services.

(7) “Level of Care Determination” means the standardized process implemented to establish the type, frequency, and duration of medically appropriate services required to treat a diagnosed behavioral health condition.

(8) “Recovery Assistant” means a provider who provides a flexible range of services. Recovery assistants provide face-to-face services in accordance with a service plan that enables a participant to maintain a home or apartment, encourages the use of existing natural supports, and fosters involvement in treatment, social, and community activities. A recovery assistant shall:

(a) Be at least 18 years old;

(b) Meet the background check requirements described in OAR 410-180-0326;

(c) Conform to the standards of conduct as described in OAR 410-180-0340.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0610 – Provider Enrollment

(1) Providers shall be enrolled with the Division as a behavioral health provider. Paid providers of behavioral health services shall possess a current and valid license, letter, or certificate.

(2) Providers shall provide services within the scope of professional standards and practice defined by the providers licensing board or certifying organization.

(3) Providers shall meet all requirements in OAR 410-120-1260 (Medical Assistance Programs Provider Enrollment), OAR 943-120-0310 (Provider Requirements), and OAR 943-120-0320 (Provider Enrollment).

(4) Providers shall not be included on any US Office of Inspector General Exclusion lists.

Stat. Auth.: ORS 413.042 and 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715


Behavior Health Services Rules

410-172-0620 – Documentation Standards

(1) OHP providers shall maintain records that fully support the extent of services for which payment has been requested and provide the records to the Division upon request.

(2) All records shall document the specific service provided, the number of services comprising the service provided, the extent of the service provided, the dates on which the service was provided, and the individual who provided the service.

(3) Clinical records shall document the recipient’s diagnosis and the medical need for the service.

(4) The record shall be annotated each time a service is provided and be signed or initialed by the individual providing the service.

(5) Information contained in the record shall be appropriate in quality and quantity to meet the professional standards applicable to the provider and any additional standards for documentation found in these rules, other Division rules, and pertinent contracts.

(6) For AMH certified providers, in addition to meeting the requirements in this rule, clinical documentation for behavioral health services shall also comply with the requirements in OAR 309-019-0135 through OAR 309-019-0140, and clinical documentation standards for substance use disorder services shall comply with OAR 309-018-0140 through OAR 309-018-0150.

Stat. Auth.: ORS 413.042, 430.640, 430.705, and 430.715

Stats. Implemented: ORS 414.025, 414.065, and 430.640
410-172-0630 – Medically Appropriate

(1) In addition to the definition of medically appropriate in OAR 410-120-0000 for behavioral health services, “medically appropriate” means the services and supports required to diagnose, stabilize, care for, and treat a behavioral health condition.

(2) The Division shall make payment for medically appropriate behavioral health services when the services or supports are:

(a) Rendered by a provider whose training, credentials, or license is appropriate to treat the identified condition and deliver the service;

(b) Based on the standards of evidence-based practice, and the services provided are appropriate and consistent with the diagnosis identified in the behavioral health assessment;

(c) Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan;

(d) Not provided solely for the convenience of the recipient, the recipient’s family, or the provider of the services or supplies;

(e) Not provided solely for recreational purposes;

(f) Not provided solely for research and data collection;

(g) Not provided solely for the purpose of fulfilling a legal requirement placed on the recipient.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Behavior Health Services Rules

410-172-0640 – Behavioral Health Services Fee Schedule

(1) The Division shall pay providers based on the Behavioral Health Services Fee Schedule (fee-for-service (FFS) payment rates for behavioral health services) posted on the Authority web site.

(2) Payment shall be made at each provider’s usual and customary charge or the Division’s published reimbursement upper payment limit, whichever is less, minus payments received or due from other payers. Payments to other specified providers shall be made according to other approved schedules.

(3) The Division’s maximum allowable rate-setting process uses a methodology that is based on the existing Medicaid fee schedule with adjustments for legislative changes and payment levels.

(4) Limitations contained in the Behavioral Health Services Fee Schedule, such as the maximum rate and the amount, duration, and scope of services provided, are subject to change at the discretion of the Division. Updates and changes are posted on the Behavioral Health Services Fee Schedule website at www.oregon.gov/oha/healthplan/pages/feeschedule.aspx.

(5) Payment shall be made for services listed in the Medicaid Behavioral Health Procedure Fee Schedule that are rendered to Medicaid-eligible individuals by a qualified provider during the period in which the provider is enrolled with the Division.

(6) For cost-reimbursed services, the provider shall maintain adequate records to thoroughly explain how the amounts reported on the cost statement were determined. The records shall be accurate and in sufficient detail to substantiate the data reported. Providers whose rates are paid based on a collective bargaining agreement are not exempt from this requirement.

(7) In accordance with 42 CFR § 405.506, a charge that exceeds the customary charge of the physician or other person who rendered the medical or other health service, or the prevailing charge in the locality, or an applicable lowest charge level may be found to be reasonable, but only where there are unusual circumstances, or medical complications requiring additional time, effort, or expense that support an additional charge, and only if it is acceptable medical or medical service practice in the locality to make an extra charge in such cases. The mere fact that the physician’s or other person’s customary charge is higher than prevailing would not justify a determination that it is reasonable.

(8) Payment by the Division does not limit the Authority or any state or federal oversight entity from reviewing or auditing a claim before or after the payment. Payment may be denied or subject to recovery if medical review, audit, or other post-payment review determines that payment for the service was not provided in accordance with applicable
Oregon Administrative Rules or the service does not meet the criteria for quality or medical appropriateness of the care.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715
410-172-0650 – Prior Authorization

(1) Some services or items covered by the Division require authorization before the service may be provided. Services requiring prior authorization are published on the Medicaid Behavioral Health Services Fee Schedule.

(2) The Division shall authorize payment for the type of service or level of care that meets the recipient’s medical need and that has been adequately documented.

(3) The Division shall authorize only services that are medically appropriate and for which the required documentation has been supplied. The Division may request additional information from the provider to determine medical appropriateness.

(4) Documentation submitted when requesting authorization shall support the medical justification for the service. The authorization request shall contain:

   (a) A cover sheet detailing relevant provider and recipient Medicaid numbers;

   (b) Requested dates of service;

   (c) HCPCS or CPT Procedure code requested; and

   (d) Amount of service or units requested;

   (e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140; or

   (f) Any additional clinical information supporting medical justification for the services requested;

   (g) For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. Providers shall use the ASAM;

   (h) For Applied Behavior Analysis (ABA) services, the Division requires submission of the following:

      (A) ABA services for the treatment of autism spectrum disorder shall have an evaluation as described in OAR 410-172-0770(1)(a–j) and a referral for treatment as described in OAR 410-172-0760(1) from one of the licensed practitioners described in OAR 410-172-0760(1)(a–d) who are, in addition, experienced in the diagnosis of autism spectrum disorder;

      (B) ABA services for the treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder shall have an evaluation
as described in OAR 410-172-0770(2) and a referral for treatment as described in OAR 410-172-0760(2) from a licensed practitioner, practicing within the scope of their license who has experience or training in the diagnosis and treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder;

(C) A treatment plan, including a functional behavior assessment, as needed, from a licensed health care professional as defined in ORS 676.802(2)(a–h), or by a behavior analyst or assistant behavior analyst licensed by the Oregon Behavior Analysis Regulatory Board, or by an individual holding a declaration of practice through the Oregon Behavior Analysis Regulatory Board as described in OAR 824-010-0005(10):

(i) Residential treatment services for children may require a letter of approval by a designated quality improvement organization (QIO);

(j) Some services require additional approval or authorization by a physician, the Authority, or designee. Services requiring additional approval are listed on the Behavioral Health Fee Schedule or described in this rule.

(5) The Division may not authorize services under the following circumstances:

(a) The request received by the Division was not complete;

(b) The provider did not hold the appropriate license, certificate, or credential at the time services were requested;

(c) The recipient was not eligible for Medicaid at the time services were requested;

(d) The provider cannot produce appropriate documentation to support medical appropriateness, or the appropriate documentation was not submitted to the Division;

(e) The services requested are not in compliance with OAR 410-120-1260 through 1860;

(f) Authorization for payment may be given for a past date of service if:

   (A) On the date of service, the recipient was made retroactively eligible or was retroactively dis-enrolled from a CCO or PHP;

   (B) The services provided meet all other criteria and Division or Authority administrative rules and;

   (C) The request for authorization is received within 90 days of the date of service.
(6) Any requests for authorization after 90 days from date of service require documentation from the provider that authorization could not have been obtained within 90 days of the date of service.

(7) Payment authorization is valid for the time-period specified on the authorization notice but may not exceed 12 months unless the recipient’s benefit package no longer covers the service, in which case the authorization shall terminate on the date coverage ends.

(8) Prior authorization of services shall be subject to periodic utilization review and retrospective review to ensure services meet the definition of medical appropriateness.

(9) Payments shall be made for the provision of active treatment services. If active treatment is not documented during any period in which the Division prior authorized the services, the Division may limit or cancel prior authorization or recoup the payments.

(10) If providers fail to comply with requests for documents for purposes of verifying medical appropriateness within the specified time-frames, the Authority may deem the records non-existent and cancel prior authorization.

(11) In applying OAR 410-141-3061, OAR 410-172-0650 (5)(f), and OAR 410-172-0650(6), the Division may construe them as much as possible to be complementary. In the event that OAR 410-141-3061 and OAR 410-172-0650(5)(f) and OAR 410-172-0650(6) may not be complementary, the Division shall apply the following order of precedence to guide its interpretation: OAR 410-141-3061, OAR 410-172-0650(5)(f), and OAR 410-172-0650(6).

Statutory/Other Authority: ORS 413.042 & 430.640

Statutes/Other Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715
Service Specific Rules
410-172-0660 – Rehabilitative Mental Health Services (T)

(1) Rehabilitative mental health services means medical or remedial services recommended by a licensed medical practitioner or other licensed practitioner to reduce impairment to an individual’s functioning associated with the symptoms of a mental disorder or substance use disorder and are intended to restore functioning to the highest degree possible.

(2) Remedial rehabilitative behavioral health services shall be recommended by a licensed practitioner of the healing arts within the scope of their practice under state law.

(3) Rehabilitative behavioral health services that include medical services shall be provided under ongoing oversight of a licensed medical practitioner.

(4) Paid providers of rehabilitative behavioral health services shall meet one of the following qualifications or hold at least one of the following educational degrees and valid licensure:

   (a) Physician or Physician Assistant licensed by the Oregon Medical Board;

   (b) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

   (c) Psychologist licensed by the Oregon Board of Psychology;

   (d) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

   (e) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

   (f) Certificate issued by AMH as described in OAR 309-012-0130 through 309-012-0220.

(5) Non-paid providers shall be supervised by a paid provider as described in this rule under a board approved plan of practice and supervision or be employed by a provider organization certified by OHA as described in OAR 309-012-0130 through 309-012-0220 and meet one of the following qualifications:

   (a) Psychologist resident as described in OAR 858-010-0037;

   (b) Psychologist associate as described in OAR 858-010-0015;
(c) Licensed Professional Counselor intern or Marriage and Family Therapist Intern registered with the Oregon Board of Licensed Professional Counselors and Therapists as described in OAR 833-050-0011;

(d) Licensed Master Social Worker licensed by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105;

(e) Board Certified Behavior Analyst issued by the Oregon Board of Behavioral Analysis Regulatory Board as described in OAR 824-030-0010;

(f) Certificate of Clinical Social Work Associates issued by the Oregon Board of Licensed Social Workers as described in OAR 877-020-0009;

(g) Registered bachelor of social work issued by the Oregon Board of Licensed Social Workers as described in OAR 877-015-0105;

(h) Qualified mental health professional as defined in OAR 309-019-0105;

(i) Qualified mental health associate as defined in OAR 309-019-0105;

(j) Mental health intern as defined in OAR 309-019-0105; or

(k) Peer-Support Specialist as defined in OAR 410-180-0305.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0670 – Substance Use Disorder Treatment Services

(1) Substance Use Disorder (SUD) treatment services include, but are not limited to, screening; assessment; individual counseling; group counseling; individual family, group or couple counseling; care coordination; medication-assisted treatment; medication management; collection and handling of specimens for substance analysis; interpretation services; detoxification for substance use disorders; synthetic opioid treatment; and acupuncture.

(2) Paid providers of SUD treatment services shall meet one of the following requirements:

(a) Outpatient substance use disorder providers shall have a certificate issued by AMH as described in OAR chapter 415 division 012;

(b) Any facility that meets the definition of a residential treatment facility for substance-dependent individuals under ORS 443.400 or a detoxification center as defined in ORS 430.306 shall have a certificate issued by AMH as described in OAR chapter 415, division 012;

(c) Synthetic opioid treatment programs shall meet the requirements described in OAR chapter 415, division 020.

(d) Substance use detoxification programs shall meet the standards described in OAR 415, chapter 050.

(e) Physician or Physician Assistant licensed by the Oregon Medical Board;

(f) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

(g) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

(h) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

(i) Psychologist licensed by the Oregon Board of Psychology;

(j) Acupuncturist licensed by the Oregon Medical Board;

(k) Non-paid providers shall be employed by a provider organization licensed or certified by AMH and meet one of the following qualifications for the scope of service provided:

(A) Qualified mental health professional as defined in OAR 309-019-0105;
(B) Qualified mental health associate as defined in OAR 309-019-0105;

(C) Mental health intern as defined in OAR 309-019-0105;

(D) Peer-support specialist as defined in OAR 410-180-0305;

(L) SUD counselor certified by a national or state accrediting body, including Certified Alcohol and Drug Counselor (CADC) certificate issued by the Addictions Counselor Certification Board of Oregon (ACCBO) including:

(A) CADC I - Requires education, supervised experience hours, and successful completion of a written examination: 150 hours of SUD education provided by an accredited or approved body; 1,000 hours of supervised experience; completion of the NCAC I professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors;

(B) CADC II – Requires a minimum of a BA or BS degree with a minimum of 300 hours of SUD education provided by an accredited or approved body; 4,000 hours of supervised experience; completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors;

(C) CADC III – Requires a minimum of a Master’s degree with a minimum of 300 hours of SUD education provided by an accredited or approved body; 6,000 hours of supervised experience; completion of the NCAC II professional psychometric national certification examination from the National Association of Alcohol and Drug Abuse Counselors.

(3) Treatment staff holding certification in addiction counseling, qualification for the certification shall include at least: 750 hours of supervised experience in substance use counseling; 150 contact hours of education and training in substance use related subjects; and successful completion of a written objective examination or portfolio review by the certifying body.

(4) For treatment staff holding a health license described in this rule, the provider shall possess documentation of at least 60 (120 for supervisors) contact hours of academic or continuing professional education in SUD treatment.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715
410-172-0680 – Residential Treatment Services for Children

(1) Paid providers of children’s psychiatric residential treatment services shall:

(a) Hold a Certificate of Approval Pursuant to OAR 309-012-0130 through 309-012-0220 from AMH; and

(b) Be accredited as a psychiatric residential treatment facility for children under age 18 by JCAHO, CARF, or any other accrediting organization with comparable standards that is recognized by the State of Oregon;

(c) Be licensed by the Office of Licensing and Regulatory Oversight (OLRO);

(2) Residential Treatment Services for Children shall provide a program consistent with standards set by JCAHO, CARF, or any other accrediting organization with comparable standards that is recognized by the state.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715
410-172-0690 – Admission Procedure for Residential Treatment Services for Children

(1) Admission procedures for children eligible for Medicaid shall be reviewed through an independent psychiatric review process established by the Division to certify the need for services.

(2) The referring source or the facility shall make available for the Certificate of Need (CONS) process the following information about the referred child:

   (a) A written psychological or psychiatric evaluation completed within the previous 60 days;

   (b) A written psychosocial history following the format required by the admission procedure of the facility to which the child has been referred;

   (c) Results of any direct recipient observation and assessment subsequent to the referral;

   (d) Other information from the referral source, other involved community agencies, and the family that are pertinent and appropriate to the admission procedure;

   (e) Level of Need Determination Process outcome and Child and Adolescent Service intensity instrument (CASII) score;

   (f) Identified care coordinator;

   (g) Identified Intensive Community Based Treatment Services (ICTS) provider;

   (h) Identified child and family team members;

   (i) Service Coordination Plan or expected date of completion;

   (j) Documentation regarding attempt or failure at lower level of care placement;

   (k) Letter from Community Mental Health Program (CMHP) approving the referral to this level of care;

   (L) Documentation that private insurance benefit will not fund stay.

(3) Certification for emergency admissions shall be made by the team responsible for a plan of care as described in CFR 441.156 within 14 days from the date of admission.

(4) The Division shall authorize payment for psychiatric residential treatment services for children upon the approval of a certificate of need by the Division or designee.
Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0705 – Residential Rate Standardization

(1) The following terms and acronyms have the described meanings when appearing in OAR 410-172-0705:

(a) “Acuity” means the level of residential service and support needs of an individual experiencing functional deficits resulting from the symptoms of a diagnosed mental health condition or complicating medical, behavioral, or cognitive conditions.

(b) “Active Engagement” means service hours provided to individuals in a residential treatment program that support personal care and other habilitative services. Active engagement hours:

   (A) May include providing habilitation services to an individual or small groups;

   (B) May occur before, during, or after the provision of ADL and IADL services for an individual;

   (C) May include offsite activities with program staff;

   (D) May not include Psychosocial Rehabilitative Services (PRS).

(c) “Activities of Daily Living (ADL)” means those personal, functional activities required by an individual for continued well-being, health, or safety. Examples of ADL include eating, dressing/grooming, bathing/personal hygiene, mobility (ambulation and transfer), elimination (toileting, bowel, and bladder management), and cognition/behavior;

(d) “Community Mental Health Program (CMHP)” means the organization of all services for individuals with mental or emotional disorders operated by, or contractually affiliated with, a local Mental Health Authority operated in a specific geographic area of the state under an intergovernmental agreement or direct contract with the Authority. CMHPs are operated pursuant to OAR chapter 309, division 014;

(e) “CMS” means Centers for Medicare and Medicaid Services, the federal agency that administers Medicaid;

(f) “De Minimis Threshold” means the Office of Management and Budget (OMB) threshold of 10 percent for government program-related administrative costs;

(g) “Direct Care” means active engagement and supervision care for individuals in a residential treatment program;

(h) “Division” or “Health Systems Division” means the Oregon Health Authority, Health Systems Division and its employees and authorized agents that is the organizational unit responsible for administration of state and federally-funded programs.
medical assistance programs including Title XIX Medicaid and Title XXI State Children’s Health Insurance Program (SCHIP);

(i) “General Ledger” means the main accounting record of a company or organization;

(j) “Habilitation” or “Habilitative Services” means services designed to help an individual attain or maintain their maximal level of independence and includes, but is not limited to, services provided in order to help an individual acquire, retain, or improve skills in ADLs and IADLS, community survival skills, communication, self-help, socialization, and adaptive skills necessary to reside successfully in an individual’s home or a community-based setting;

(k) “Home and Community Based Services (HCBS)” means services and supports that assist eligible individuals to remain in their home and community in accordance with the Code of Federal Regulations and Oregon Administrative Rules;

(L) “Independent and Qualified Agent (IQA)” means Oregon’s contracted vendor to perform functional needs assessments, person-centered service planning service coordination, transition coordination, service authorizations, and utilization review and management for individuals requesting or receiving 1915(i) Home and Community-Based Services, other Medicaid-funded behavioral health services, or state General Fund behavioral health services in an individual’s home or a community-based setting. The IQA conducts initial and annual 1915(i) HCBS State Plan Amendment eligibility determinations and redeterminations;

(m) “Instrumental Activities of Daily Living (IADL)” means those self-management activities performed by an individual on a day-to-day basis but are not essential to basic self-care and independent living. Examples of IADLS include but are not limited to housekeeping, laundry, shopping, transportation, medication management and meal preparation;

(n) “Level of Service Inventory (LSI)” means a person-centered assessment of the residential service and support needs of an individual experiencing functional deficits resulting from the symptoms of a diagnosed mental health condition;

(o) “Minimum Wage Regions” means geographic areas within Oregon in which fixed minimum hourly wage rates are set lower than the minimum wage rate as authorized by ORS 653.025;

(p) “Per Diem” means a payment made for each day an approved service is provided;

(q) “Performing Provider” means the direct care staff member actually providing a service to an individual in a residential treatment program or separately billing a rehabilitative service to an individual residing in a residential treatment program;
(r) "Person-Centered Service Plan (PCSP)" means the written description of the supports, desired outcomes, activities, and resources required for an individual to achieve and maintain personal goals, health, and safety as described in OAR 411-004-0030 and developed in compliance with OAR 309-035-0185 through 0190. The PCSP must be completed and signed prior to the individual receiving HCBS;

(s) “Personal Care” means assistance with the performance of ADLs and IADLs;

(t) “Program Capacity” means the number of beds licensed for residential treatment in a location;

(u) “Provider” means an individual, organizational provider, or CMHP that is enrolled by the Division to provide personal care, other habilitative services, or PSR;

(v) “Psychosocial Rehabilitation Services (PSR)” means medical or remedial services recommended by a licensed physician or other licensed practitioner to reduce impairment to an individual’s functioning associated with the symptoms of a mental disorder or to restore functioning to the highest degree possible;

(w) "Related Organization" means an entity that is under common ownership or control with, has control of, or is controlled by another organization. An entity is related if it has:

   (A) Five percent or more ownership interest in the other organization; or
   
   (B) Capacity derived from any financial or other relationship, whether exercised, to directly or indirectly influence or direct the activities of the other organization.

(x) "Residential Treatment Facility (RTF)" has the meaning provided in ORS 443.400(11) subject to exclusions as provided in ORS 443.405;

(y) "Residential Treatment Home (RTH)" has the meaning provided in ORS 443.400(12) subject to exclusions as provided in ORS 443.405;

(z) “Resident” means an individual receiving treatment in a residential treatment program;

(aa) "Residential Services Costs" means costs associated with the provision of mental health services to individuals in residential treatment programs. Costs include direct and indirect services required to meet an individual’s assessed needs for personal care and other habilitative services. Residential services costs do not include costs related to providing psychosocial rehabilitation services (PSR);

(bb) “Residential Treatment Program” means a RTF, RTH, SRTF, and YAT facility that is licensed to provide mental health services but does not include adult foster homes as defined in OAR 309-040-0305;
(cc) “Retainer Payment” means a payment made for medical, behavioral, or psychiatric related temporary absences of 30 days or less from residential treatment programs for which the Division has provided prior authorization;

(dd) "Secure Residential Treatment Facility (SRTF)” has the meaning provided by OAR 309-035-0105(60);

(ee) "Standardized Rate" means a tiered payment rate for personal care and other habilitative services in a residential treatment program based on individual acuity, program capacity, and minimum wage regions;

(ff) "Start-Up Costs" means one-time costs incurred prior to the first resident being admitted;

(gg) “Supervision Hours” means the staff hours in a mental health residential treatment program for overseeing patients’ general activities throughout the day;

(hh) “Young Adult in Transition Facility (YAT)” means a facility when that facility is providing services to an individual who is developmentally transitioning into independence as defined in OAR 309-019-0105 and is of an age not less than 17 years and six months, and not more than 25 years.

(2) The Division applies a standardized rate for payment of personal care and other habilitative services provided in a residential treatment program.

(3) The Division develops standardized rates with a standardized rate methodology based on data from residential treatment programs that is collected and analyzed by an independent third party. The independent third party must collect and analyze provider general ledger cost data for the most recent full year of operation and must examine job classification and wage data.

(4) The analysis of the independent third party referred to in section (3) must:

   (a) Align general ledger data;

   (b) Evaluate the intensity of the staffing needs in terms of client acuity and level of need;

   (c) Determine the cost of active engagement hours and supervision hours;

   (d) Analyze program capacity to account for direct care and support costs related to the number of individuals in the home;

   (e) Analyze geographic cost variations.

(5) The Division shall re-evaluate provider general ledger data at five-year increments.
(6) Subject to legislative funding and approval, the Division may trend the standardized rate to the annual Consumer Price Index (CPI) the state applies for the state's minimum wage.

(7) Standardized rates for residential treatment programs are intended to pay for the following:

   (a) Residential services costs for individual services and supports for residents of residential treatment programs including ADLs, IADLs, other habilitation services, and related indirect costs;

   (b) Five percent vacancy rate for providers to use as a reserve.

(8) The following cost items may not be included in the calculation of standardized rates:

   (a) Resident paid room and board;

   (b) Psychosocial rehabilitation services;

   (c) Medical services;

   (d) Costs incurred by a related organization that are not directly incurred for residential treatment program services;

   (e) Administrative costs in excess of the de minimis threshold of ten percent of allowed costs; and

   (f) Program start-up costs.

(9) The Division may use residential services costs in developing standardized rates as follows:

   (a) On request of the Division, residential treatment programs must provide general ledger cost data that capture the most recent full year of operation;

   (b) The Division may analyze provider costs by aggregating general ledger information from multiple residential treatment programs to identify relationships between direct care costs and other cost components such as employee benefits, training, transportation, and program-related facility costs;

   (c) The Division may calculate the rates for each rate tier based on the amount and type of direct care hours, including active engagement hours and supervision hours.

(10) The maximum allowable rate the Division pays per client under the standardized rate methodology shall be according to rate tiers. The Division shall publish a table with specific rate amounts in the Behavioral Health Fee Schedule. Tiers shall be defined by but not limited to the following variables:
(a) Levels of need based on individual acuity;

(b) Program type and capacity; and

(c) Minimum wage regions.

(11) The standardized rate tier is assigned to an individual based upon an independent face-to-face assessment of an individual’s need and acuity that is documented in a PCSP. The assessment classifies residents and prospective residents of residential treatment programs into acuity-based tiers of:

(a) Tier 1 for either an empty bed or an individual whose acuity assessment significantly improves to no longer require the level of support provided in a residential setting, but the individual has chosen to remain in the residential setting;

(b) Tier 2 for an individual with an LSI of 40 or less;

(c) Tier 3 for an individual with an LSI of 41-60;

(d) Tier 4 for an individual with an LSI of 61-79; and

(e) Tier 5 for an individual who is in a residential treatment home or facility that is not part of a secure or young adults in transition program and who is either of the following:

(A) An individual with an LSI of 80 or more; or

(B) An individual with an LSI of less than 80 who the IQA and the Authority agree meets one of the following severity of need criteria, either temporarily during rehabilitation or ongoing, and who is approved for Tier 5 level of care under subsection (11) (f) of this rule:

(i) The individual’s medical, behavioral, or cognitive diagnosis severely interferes with treatment and self-care with PCSP and requires frequent monitoring and redirection throughout the day; or

(ii) The individual’s intensity and frequency of care varies, and the individual requires frequent monitoring and redirection to prevent decompensating episodes and potential harm to self or others.

(f) Approval of Tier 5 level of care under the provisions of subsection (11)(e)(B) for each initial or additional time period must be based on an evaluation of the individual’s PCSP, progress, and continued severity of need and may include:

(A) Approval for an initial period not to exceed three months;

(B) Approval for an additional six-month period; and

(C) Approval for additional periods of 6-12 months.
(12) Client individual acuity used to determine the standardized rate in the Division’s table shall be measured by an LSI instrument approved by the Division.

(13) The Division may designate providers of assessments of client individual acuity, which may include:

   (a) The Authority staff qualified to perform an assessment;

   (b) The Division’s contracted IQA; or

   (c) Other entities specified by the Authority.

(14) The Division may authorize acuity reviews for the assignment of individuals to residential treatment rate tiers as follows:

   (a) In preparation for a placement from the Oregon State Hospital (OSH) to a residential treatment program;

   (b) In preparation for a residential treatment program placement from sources other than OSH;

   (c) As part of an annual review by IQA for HCBS eligibility redetermination; or

   (d) For residents with a significant change in acuity that lasts longer than 30 days.

(15) Providers may request the IQA to perform an assessment and reauthorization of services for an individual with a significant change in acuity exceeding 20 points on the LSI instrument and lasting longer than 30 days.

(16) The Division may pay for services under the standardized rate methodology only when all the following requirements have been met with respect to the service:

   (a) All individuals must receive daily supervision;

   (b) Tier 2 must receive an average of three or more hours of active engagement daily;

   (c) Tier 3 must receive an average of five or more hours of active engagement daily;

   (d) Tier 4 must receive an average of six or more hours of active engagement daily;

   (e) Tier 5 must receive an average of seven or more hours of active engagement daily;

   (f) A performing provider in residential treatment programs, including a provider of habilitation and PRS, must be enrolled with the Division and identified in claiming services as the performing provider;
(g) A residential treatment program must have sufficient staff to meet active engagement and supervision hours as required by subsections (a), (b), (c), (d), and (e) of this section during engagement hours. Refer to OAR 309-035-0135 for licensed residential treatment program staff requirements;

(h) A residential treatment program shall maintain adequate records to accurately substantiate all amounts reported in a general ledger and other cost statements;

(i) A residential treatment program must document at least daily the specific individual personal care and other habilitative services including skills building and other activities provided to enhance community integration, the individual's response to services provided, and planned activities related to the individual's assessment and PCSP;

(j) Upon request of the Division, a residential treatment program must provide monthly site-specific census data that includes individuals' acuity assessment scores and any discharges or referrals and must report changes to submitted census data at least weekly.

(17) The Division’s payment of Medicaid allowable standardized rates for residential treatment program services including personal care and other habilitation services is considered payment in full and precludes any General Fund contract or other supplemental funding for Medicaid-allowable costs and services.

(18) Residential treatment program providers may not:

(a) Collect funds from any resident in excess of the room and board costs;

(b) Accept funds from any other source for services paid by Medicaid; or

(c) Submit claims for individual habilitation or PSR services that duplicate the per diem payment for residential personal care and other habilitation services.

(19) Standardized rates developed using Medicaid-allowable costs, policies and processes apply when the Division makes payment for services to non-OHP residents of residential treatment programs.

(20) Beginning July 1, 2019, PRS provided to residents of a residential treatment programs must be billed using individual services or unit billing, and the Division may not pay PSR using bundled per diem rates.

(21) The Division may pay a retainer payment to residential treatment programs:

(a) The Authority may pay a retainer payment for residents in residential treatment programs for medical or psychiatric related temporary absences lasting 30 days or less;
(b) The Division may authorize and make a payment when an individual is absent in order to be:

(A) Admitted to an acute care hospital;

(B) Admitted to a respite facility to avoid re-hospitalization or revocation of a conditional release order; or

(C) Transferred from a hospital, or another residential setting.

Statutory/Other Authority: ORS 413.042 & 430.640

(c) A retainer payment for temporary absences of 30 days or less from residential treatment programs requires the Division prior authorization. A prior authorization request must include:

(A) Requested dates of service;

(B) HCPCS or CPT procedure code requested;

(C) The amount of service or units requested; and

(D) Additional clinical information supporting medical or psychiatric justification for the services requested, particularly the medical or psychiatric rationale for temporary absence.

Statutes/Other Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705 & 430.715
410-172-0710 – Residential Personal Care

(1) Personal care services provided to a resident of an AMH licensed residential treatment program include a range of assistance, as developmentally appropriate, and are provided to individuals with behavioral health conditions that enable them to accomplish tasks that they would normally do for themselves if they did not have a behavioral health condition. Assistance may be in the form of hands-on assistance (actually performing a personal care task) or cueing (redirecting) so that the individual performs the task by him or herself.

(2) Personal care assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management.

(3) Personal care services may be provided on a continuing basis or on episodic occasions.

(4) Paid providers of facility-based personal care services shall meet one of the following:

   (a) Licensed residential facility pursuant to OAR chapter 309, divisions 035 and 040;

   (b) Secure Residential Treatment Facility (SRTF);

   (c) Residential Treatment Facility (RTF);

   (d) Residential Treatment Home (RTH);

   (e) Adult Foster Home (AFH).

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715
410-172-0720 – Prior Authorization and Re-Authorization for Residential Treatment

(1) The Authority does not consider a request for a fixed episode of care or standardized length of stay to be medically appropriate. Requested length of stay shall be based on an assessment of individual need and the medical appropriateness of the proposed time for treatment.

(2) Residential treatment is intended as an outcome-based, transitional, and episodic period of care to provide service and supports in a structured environment that allows the individual to successfully re-integrate into an independent community-based living arrangement.

(3) Residential treatment is not intended to be used as a long-term substitute for lack of available supportive living environment in the community.

(4) Authority licensed residential treatment programs are reimbursed for the provision of rehabilitation, substance use disorder, habilitation, or personal care services as defined in these rules.

(5) The Division shall authorize admission and continued stay in residential programs based on the medical appropriateness of the request and supporting clinical documentation.

(6) Prior authorization requests for admission and continued stay may be reviewed to determine:

   (a) The medical appropriateness of the admission for residential services provided;

   (b) The appropriateness of the recommended length of stay;

   (c) The appropriateness of the recommended plan of care;

   (d) The appropriateness of the licensed setting selected for service delivery;

   (e) A level of care determination was appropriately documented.

(7) Prior authorization requests for admission and continued stay for a Secured Residential Treatment Facility (SRTF) shall also be reviewed to confirm that the individual meets all the following criteria:

   (a) The individual does not require 24-hour hospital care and treatment;

   (b) The individual requires highly structured environmental supports and supervision seven days a week and 24 hours a day in order to participate successfully in a program of habilitative and rehabilitative activities;
(c) Due to a mental illness and as evidenced by clinical documentation from the last 90 days or from an Authority-approved and standardized risk assessment conducted within the past year, the individual presents a risk in one of the following areas:

(A) Clear intention or specific acts of bodily harm to others;

(B) Suicidal ideation with intent, or self-harm posing significant risk of serious injury;

(C) Inability to care for basic needs that results in exacerbation or development of a significant health condition, or the individual’s mental health symptoms impact judgment and awareness to the degree that the individual may place themselves at risk of imminent harm.

(D) Due to the symptoms of a mental illness, there is significant risk that the individual will not remain in a place of service for the time needed to receive the services and supports necessary to stabilize the symptoms of a mental illness that pose a threat to the individual's safety and well-being.

(8) If the Division determines that a residential service prior authorization request is not within coverage parameters, the provider shall be notified in writing and shall have ten business days to provide additional written documentation to support the medical appropriateness of the admission and procedures.

(9) If the reconsidered decision is to uphold the denial, prior authorization shall be denied.

(10) The provider may appeal any final decision through the Division administrative appeals process as described in OAR 410 120-1560 through 1875.

(11) Upon denial of a prior authorization request for continued stay, the Division shall authorize payment for up to 60 days of continued stay for the purposes of supporting transition management and planning for the recipient.

(12) The Division shall determine re-authorization and authorization of continued stays based upon one of the following:

(a) The recipient continues to meet all basic elements of medical appropriateness;

(b) One of the following criteria shall be met:

(A) Documentation that the treatment provided is resulting in measurable clinical outcomes but that the recipient is not sufficiently stabilized or yet developed the skills necessary to support transition to a less restrictive level of care;
(B) The recipient develops new or worsening symptoms or behaviors that require continued stay in the current level of care.

(13) Requests for continued stay based on these criteria shall include documentation of ongoing reassessment and necessary modification to the current treatment plan or residential plan of care.

Statutory/Other Authority: ORS 413.042 & 430.640

Statutes/Other Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705 & 430.715
410-172-0730 – Payment Limitations for Behavioral Health Services

(1) Services shall be subject to periodic utilization review to determine medical appropriateness.

(2) If a review reveals that a recipient received less than active treatment, payment may not be allowed under these rules and prior authorization may be cancelled.

(3) The Division may make no payment for services if the Division or designee has determined the service is not medically appropriate.

(4) Residential treatment services are provided to Medicaid Title XIX eligible individuals in facilities with 16 or fewer beds. Payment is excluded for individuals in “institutions of mental diseases” (IMD) who are over age 18 and under age 65. IMDs are defined in 42 CFR 435.1010.

(5) For residential facilities, the Division shall pay for the day of admission but may not pay for the day of transfer or discharge.

(6) Medicaid may not reimburse costs associated with room and board for recipients residing in Authority licensed residential treatment programs.

Statutory/Other Authority: ORS 413.042 & 430.640

Statutes/Other Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705 & 430.715
410-172-0740 – Supported Employment

(1) To be eligible for Medicaid reimbursement, supported employment (SE) services shall be provided by a qualified SE provider.

(2) To become a qualified SE provider, an agency shall provide the evidence-based practice of individual placement support (IPS) and SE and submit a copy to AMH of a fidelity review conducted by an AMH approved fidelity reviewer that resulted in a score of 100 or better.

(3) Providers implementing IPS supported employment may become a provisionally-qualified SE provider by submitting a request to AMH with a letter of support that indicates receipt of technical assistance and training from an AMH approved IPS SE trainer. Medicaid reimbursement to a provisionally-qualified SE provider ends after 12 months. This option is intended only for providers initiating SE services.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
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410-172-0745 – Exception Criteria for Facial Gender Confirmation Surgery (FGCS)

(1) The following definitions apply to this rule:

(a) “Community Life Activities” means activities such as but not limited to attending school or participating in employment;

(b) “Facial Gender Confirmation Surgery” means a constellation of surgical procedures intended to produce facial features that will be perceived by others as congruent with an individual’s gender identity. The goal of facial gender confirmation surgery is to reduce gender non-congruence that causes persistent gender dysphoria and severe life interruptions such as the impairment of an individual’s ability to participate in community life. Facial gender confirmation surgery may include but is not limited to frontal bone reshaping, mandible bone reshaping, cheek augmentation, rhinoplasty, tracheal shaving, and electrolysis or laser hair reduction procedures, depending on the severity of non-congruence of individual facial features;

(c) “Severe Mental Health Comorbid Condition,” for the purposes of this rule, means a condition such as but not limited to PTSD or anxiety including agoraphobia, severe depression, or suicidal ideation, due to experiencing or fear of experiencing physical violence based on marked facial gender non-congruence.

(2) Facial Gender Confirmation Surgery for treatment of gender dysphoria is not paired with gender dysphoria above the funded line on the Prioritized List of Health Services as referenced in OAR 410-141-0520. A member who meets the following criteria may be considered for coverage of medically necessary and appropriate facial gender confirmation procedures:

(a) Having a severe mental health comorbid condition that prevents the member from participating in community life; and

(b) Member receives medically necessary and appropriate non-surgical treatments for mental health comorbidity as recommended by the treatment team, and non-surgical treatments are determined to be insufficient to enable participation in community life; and

(c) Member experienced a gender identity non-congruent hormonal puberty; and

(d) Purpose of the surgery is to achieve a minimum level of facial gender congruence in order to be publicly identified as gender congruent and not solely to improve appearance; and

(e) Facial gender confirmation surgery is necessary to achieve the benefits of the funded treatments for gender dysphoria: Mental health care, hormone therapy, and sex reassignment surgery also known as gender confirmation surgery; and
(f) Member meets all the applicable requirements in Guideline Note 127, Gender Dysphoria of the Prioritized List in subsections (a, b, and d) for cross-sex hormone therapy and subsection (f) for sex reassignment surgery, also known as gender confirmation surgery, as referenced in OAR 410-141-0520;

(g) All other conditions of OAR 410-141-0480(11) are met;

(h) The surgery is medically necessary and appropriate as defined in OAR 410 120 0000.

Stat. Auth.: ORS 413.042 and 430.640
Stats. Implemented: ORS 413.042 and 430.640
410-172-0750 – Assertive Community Treatment (ACT)

(1) Assertive Community Treatment (ACT) services shall be provided by a qualified ACT provider to be eligible for Medicaid reimbursement.

(2) An agency shall provide the evidence-based practice of ACT to become a qualified ACT provider and submit to AMH a copy of a fidelity review conducted by an AMH approved ACT Fidelity Reviewer with a minimum score of 114.

(3) Agencies may become a provisionally-qualified ACT provider by submitting to AMH a request with a letter of support that indicates receipt of technical assistance and training from an AMH approved ACT Trainer. Provisional ability to receive Medicaid reimbursement shall end after 12 months. This option is intended only for providers initiating ACT services.

(4) If a Qualified ACT provider does not receive a minimum score of 114 on a fidelity review, the following shall occur:

   (a) Technical assistance shall be made available for a period of 90 days to address problem areas identified in the fidelity review;

   (b) At the end of the 90-day period, a follow-up review shall be conducted by an AMH approved reviewer.

(5) The provider shall forward a copy of the amended fidelity review report to AMH.

(6) If the 90-day review results in a score of less than 114, the agency’s designation as a Qualified ACT provider may be suspended for up to one calendar year.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0760 – Applied Behavior Analysis

(1) Applied Behavior Analysis (ABA) services for the treatment of autism spectrum disorder shall be recommended by a licensed practitioner who has experience in the diagnosis and treatment of autism spectrum disorder and holds at least one of the following educational degrees and valid license:

(a) Physician;

(b) Psychologist;

(c) Nurse practitioner specializing in developmental medicine, or;

(d) Physician’s assistant specializing in developmental medicine.

(2) ABA services for the treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder shall be recommended by a licensed practitioner, practicing within the scope of their license, who has experience or training in the diagnosis and treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder.

(3) Providers of ABA services eligible for direct payment shall hold the following license, registration, or declaration of practice:

(a) Licensed Behavior Analyst as described in OAR 824-030-0010;

(b) Licensed health care professional as defined in 2015 Oregon Laws Chapter 674, section 1 who is registered with the Oregon Behavior Analyst Certification Board as described in ORS 676.802 (2)(a-h);

(c) Individual holding a declaration of practice through the Oregon Behavior Analysis Regulatory Board as described in OAR 824-010-0005(10).

(4) The following ABA service providers are not eligible for direct payment:

(a) Assistant Behavior Analyst licensed by the Oregon Behavior Analysis Regulatory Board as described in OAR 824-030-0020;

(b) Behavior Analysis Interventionists registered by the Oregon Behavior Analysis Regulatory Board as described in OAR 824-030-0040.

(5) Initial and ongoing six month assessments of core skills by ABA licensed providers for the purpose of measuring progress achieved during ABA treatment must:

(a) Use standardized, validated and reliable assessment tools that allow for tracking an individual’s progress over time;
(b) Result in a treatment plan with specific, observable, and quantifiable goals that are relatable to identified skills deficits.

(6) Initial and ongoing six month assessments of behavior that is considered to have an adverse impact on the individual’s development or is harmful to the individual or to others must have treatment goals that are specific, observable, and quantifiable and must relate to identified behavioral concerns.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.71
410-172-0770 – Individual Eligibility for Applied Behavioral Analysis Treatment

(1) Prior to receiving services, individuals receiving ABA services for the treatment of autism spectrum disorder (ASD) shall have an evaluation by a licensed practitioner, described in OAR 410-172-0760(1)(a-d), experienced in the diagnosis and treatment of autism using the current DSM criteria that includes:

(a) A diagnosis of an ASD listed on the ASD line of the Health Evidence Review Commission’s (HERC) Prioritized List;

(b) Documentation of and results from a standardized, validated tool, such as the Autism Diagnostic Observation Schedule (ADOS), that has been used to substantiate the autism disorder;

(c) Documentation of individual core features of autism as identified through a review of ASD diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders (DSM 5);

(d) Documentation that a parent or caregiver has been interviewed;

(e) Documentation that there was a review of relevant medical records;

(f) Documentation that the practitioner was able to observe the individual directly;

(g) Documentation of developmental status using validated assessments or a combination of such assessments, such as the Vineland. This information may be provided by a licensed ABA provider;

(h) Documentation of a comprehensive medical exam. A physical exam from the most recent well child care visit may be submitted if within one year for children aged 1-6, or within two years for children 6-18. The physical exam must be completed before starting ABA but may not be allowed to delay or interrupt ABA services;

(i) Documentation that an audiology or hearing test has been performed within one year for children aged 2 through 5, or within two years for children aged 6 through 18. The audiology or hearing test must be completed before starting ABA but may not be allowed to delay or interrupt ABA services:

   (A) Newborn assessment is not sufficient after the age of 24 months;

   (B) Hearing tests from primary care offices and schools are sufficient if there are no concerns regarding hearing;

(j) Any other documentation, if available, that would substantiate the diagnosis of autism or stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder including but not limited to the following:
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(A) Notes from well-child visits or other medical professionals;

(B) Results from any additional assessments including but not limited to IQ, achievement tests, speech and language tests, and assessments of adaptive functioning.

(k) A referral for ABA treatment with or without specification of hours or intensity that shall include:

(A) A diagnosis of ASD or stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder;

(B) A copy of the evaluation described in 410-172-0770 (1); 

(C) A referral for ABA treatment with or without specification of hours or intensity.

(2) Prior to receiving services, individuals receiving ABA for the treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder shall have an evaluation by a licensed practitioner, practicing within their scope of practice, who has training or experience in the diagnosis and treatment of stereotyped movement disorder with self-injurious behavior due to neurodevelopmental disorder that includes results from a questionnaire or observations that have been used to substantiate the diagnosis.

(3) Prior authorization for intensive and less intensive interventions must be based on an individualized determination of medical appropriateness for each individual and relevant guideline notes from the HERC Prioritized List at the initiation and continuation of ABA services. Services in excess of the HERC Prioritized List coverage guidance or guideline notes shall be provided when medically appropriate for a particular individual, including individuals age 13 and older. Relevant factors to consider when making a prior authorization determination include but are not limited to the following:

(a) Severity;

(b) Depth and breadth of previous treatment;

(c) How recently the diagnosis has been made. For example, if the diagnosis has been made after the child turned 13, intensive treatment shall be considered;

(d) Comorbidities such as psychiatric disorders, developmental delays, and intellectual disability may make it harder to treat ASD and may require more intensity of treatment to be effective;

(e) Factors that would be contrary to the efficacy of ABA or increased intensity of ABA services.
Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430
Behavior Health Services Rules

410-172-0780 – Behavioral Health Personal Care Attendant Program

(1) Behavioral health personal care attendant services are essential services that enable an individual to move into or remain in his or her own home. Behavioral health personal care attendant services are provided in accordance with an individual’s authorized plan for services by a QMHA or QMHP as defined in OAR 309-019-0105:

(a) Behavioral health personal care attendant services are provided directly to an eligible individual and are not meant to provide respite or other services to an individual’s natural support system. Behavioral health personal care attendant services may not be implemented for the purpose of benefiting an individual’s family members or the individual’s household in general;

(b) Behavioral health personal care attendant services are limited to 20 hours per month per eligible individual;

(c) To meet an extraordinary personal care need, an individual, representative, or legal representative may request an exception to the 20-hour per month limitation. An exception shall be requested through the local community mental health program or agency contracted with the Authority serving the individual. The Division has up to 45 days upon receipt of an exception request to determine whether an individual’s assessed personal care needs warrant exceeding the 20-hour per month limitation.

(2) Personal care services include:

(a) Basic personal hygiene, providing or assisting an individual with such needs as bathing (tub, bed bath, shower), washing hair, grooming, shaving, nail care, foot care, dressing, skin care, mouth care, and oral hygiene;

(b) Toileting, bowel, or bladder care, assisting to and from bathroom, on and off toilet, commode, bedpan, urinal, or other assistive device used for toileting, changing incontinence supplies, following a toileting schedule, cleansing an individual or adjusting clothing related to toileting, emptying a catheter drainage bag or assistive device, ostomy care, and bowel care;

(c) Mobility, transfers, or repositioning, assisting an individual with ambulation or transfers with or without assistive devices, turning an individual or adjusting padding for physical comfort or pressure relief, and encouraging or assisting with range-of-motion exercises;

(d) Nutrition, preparing meals and special diets, assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with special utensils, cutting food, and placing food, dishes, and utensils within reach for eating;
(e) Medication or oxygen management, assisting with ordering, organizing, and administering oxygen or prescribed medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring for choking while taking medications, assisting with the administration of oxygen, maintaining clean oxygen equipment, and monitoring for adequate oxygen supply;

(f) Delegated nursing tasks, as defined in OAR 411-034-0010.

(3) When any of the services listed in section (2) of this rule are essential to the health, safety, and welfare of an individual and the individual is receiving personal care paid by the Division, the following support services may also be provided:

(a) Housekeeping tasks necessary to maintain the individual in a healthy and safe environment, including cleaning surfaces and floors, making the individual's bed, cleaning dishes, taking out the garbage, dusting, and gathering and washing soiled clothing and linens. Only the housekeeping activities related to the individual's needs may be considered in housekeeping;

(b) Arranging for necessary medical appointments including help scheduling appointments and arranging medical transportation services (described in OAR chapter 410, division 136) and assistance with mobility and transfers or cognition in getting to and from appointments or to an office within a medical clinic or center;

(c) Observing the individual's health status and reporting any significant changes to physicians, health care professionals, or other appropriate persons;

(d) First aid and handling of emergencies, including responding to medical incidents related to conditions such as seizures, spasms, or uncontrollable movements where assistance is needed by another individual and responding to an individual's call for help during an emergent situation or for unscheduled needs requiring immediate response; and

(e) Cognitive assistance or emotional support provided to an individual by another person due to confusion, dementia, behavioral symptoms, or mental or emotional disorders. Cognitive assistance or emotional support includes helping the individual cope with change and assisting the individual with decision-making, reassurance, orientation, memory, or other cognitive symptoms.

(4) Payment may not be made for any of the following excluded services:

(a) Shopping;

(b) Community transportation;

(c) Money management;
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(d) Mileage reimbursement;

(e) Social companionship;

(f) Day care, adult day services (described in OAR chapter 411, division 066), respite, or baby-sitting services;

(g) Medicaid home delivered meals (described in OAR chapter 411, division 040);

(h) Care, grooming, or feeding of pets or other animals; or

(i) Yard work, gardening, or home repair.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0790 – Eligibility for Behavioral Health Personal Care Attendant Services

(1) To be eligible for Behavioral Health personal care attendant services, an individual shall:

(a) Demonstrate the need for assistance from a qualified provider due to a disabling behavioral health condition with personal care services and meet the eligibility criteria described in this rule;

(b) Be a current recipient of a Medicaid OHP full benefit package.

(2) An individual is not eligible to receive Behavioral Health personal care attendant services if:

(a) The individual is receiving personal care services from a licensed 24-hour residential services program (such as an adult foster home, residential treatment home, or residential treatment facility);

(b) The individual is in a prison, hospital, sub-acute care facility, nursing facility, or other medical institution;

(c) The individual’s assessed service needs are being met under other Medicaid-funded home and community-based service options of the individual’s choosing.

(3) Behavioral health personal care attendant services are not intended to replace routine care commonly needed by an infant or child typically provided by the infant’s or child’s parent.

(4) Behavioral health personal care attendant services may not be used to replace other non-Medicaid governmental services.

(5) The Authority may close the eligibility and authorization for Behavioral Health personal care attendant services if an individual fails to:

(a) Employ a provider that meets the requirements in this rule;

(b) Receive personal care from a qualified provider paid by the Authority for 30 continuous calendar days or longer.

(6) Behavioral health personal care attendant services may not duplicate other Medicaid services.

(7) Individuals eligible for Behavioral Health personal care attendant services as described shall apply through the local community mental health program or agency contracted with AMH.
Behavior Health Services Rules

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715
410-172-0800 – Personal Care Attendant Employer-Employee Relationship

(1) The relationship between a provider and an eligible individual or the individual’s representative is that of employee and employer.

(2) As an employer, the individual shall create and maintain a job description for a potential provider that is in coordination with the individual’s plan for services.

(3) The only benefits available to homecare and personal support attendants are those negotiated in a collective bargaining agreement and as provided in statute. The collective bargaining agreement does not include participation in the Public Employees Retirement System or the Oregon Public Service Retirement Plan. Homecare and personal support workers are not state or Division employees.

(4) To be eligible for Behavioral Health personal care attendant services, the individual or the individual’s representative shall demonstrate the ability to:

   (a) Locate, screen, and hire a provider meeting the requirements described in this rule;

   (b) Supervise and train a provider;

   (c) Schedule work, leave, and coverage;

   (d) Track the hours worked and verify the authorized hours completed by a provider;

   (e) Recognize, discuss, and attempt to correct any performance deficiencies with the provider and provide appropriate, progressive, disciplinary action as needed; and

   (f) Discharge an unsatisfactory provider.

(5) The Authority shall pay for Behavioral Health personal care attendant services to the provider on an individual’s behalf. Payment for services is not guaranteed until the Authority has verified that an individual’s provider meets the qualifications set forth in this rule.

(6) In order to receive Behavioral Health personal care attendant services from a personal support worker or homecare worker, an individual shall be able to meet or designate a representative to meet the employer responsibilities in section (4) of this rule.

(7) Termination and the grounds for termination of employment are determined by an individual or the individual’s representative. An individual may terminate an employment relationship with a provider at any time and for any reason. An individual shall establish an employment agreement at the time of hire. The employment agreement may include grounds for dismissal, notice of resignation, work scheduling, and absence reporting.
Behavior Health Services Rules

(8) After appropriate intervention, an individual unable to meet the employer responsibilities in section (4) of this rule may be determined ineligible for Behavioral Health personal care attendant services.

(9) An individual determined ineligible for Behavioral Health personal care attendant services may request these services at the individual’s next annual re-assessment. Improvements in health and cognitive functioning may be factors in demonstrating the individual’s ability to meet the employer responsibilities described in section (4) of this rule. The waiting period may be shortened if an individual is able to demonstrate the ability to meet the employer responsibilities sooner than the individual’s next annual re-assessment.

(10) An individual may designate a representative to act on the individual’s behalf to meet the employer responsibilities in section (4) of this rule. An individual’s legal representative may be designated as the individual’s representative:

   (a) The Authority may deny an individual’s designation of a representative if the representative has:

       (A) A history of a substantiated abuse of an adult as described in OAR chapter 411, division 20, OAR chapter 407, division 45, or OAR chapter 943, division 45;

       (B) A history of founded abuse of a child as described in ORS 419 B.005;

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

       (D) Failed to meet the employer responsibilities, including previous termination for failure to meet the employer responsibilities in section (4) of this rule.

   (b) An individual may select another representative if the Authority suspends, terminates, or denies an individual’s designation of a representative.

(11) An individual with a guardian shall have a representative for service planning purposes. A guardian may designate themselves the individual’s representative.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0810 – Personal Care Attendant Qualifications

(1) A qualified provider is an individual who, in the Authority’s judgment, demonstrates by background, skills, and abilities knowledge and ability to perform or to learn to perform the required work. A qualified provider shall:

(a) Maintain a drug-free work place;

(b) Complete the background check process described in OAR 943, division 007 with an outcome of approved or approved with restrictions;

(c) May not be an individual’s legal representative;

(d) Be authorized to work in the United States in accordance with U.S. Department of Homeland Security, Bureau of Citizenship and Immigration rules;

(e) Be 18 years of age or older.

(2) A qualified provider may be employed through a contracted in-home care agency or enrolled as a homecare worker or personal support worker under a provider number. The Authority shall establish the rates for services.

(3) Providers that provide Behavioral Health personal care attendant services shall:

(a) Be enrolled in the Consumer-Employed Provider Program and meet all of the standards in OAR chapter 411, division 31;

(b) Meet the provider enrollment and termination criteria described in OAR 411-031-0040 for personal support workers.

(4) The Authority shall conduct background rechecks at least every other year from the date a provider is enrolled. The Authority may conduct a recheck more frequently based on additional information discovered about a provider, such as possible criminal activity or other allegations.

(5) Prior background check approval for another Authority provider type is inadequate to meet background check requirements for homecare or personal support workers.

(6) Provider enrollment may be inactivated when a provider fails to comply with the background recheck process. Once a provider’s enrollment is inactivated, the provider shall reapply and meet the requirements described in these rules to reactivate provider enrollment.

Stat. Auth.: ORS 413.042, 430.640
Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0820 – Provider Termination

(1) The Authority may deny or terminate a personal care attendant’s provider enrollment and provider number as described in OAR 411-031-0050. The termination, administrative review, and hearings rights for homecare workers are set forth in OAR 411-031-0050.

(2) The Authority may deny or terminate a personal support worker’s provider enrollment and provider number when the personal support worker:

(a) Has been appointed the legal guardian of an individual;

(b) Has a background check that results in a closed case pursuant to OAR chapter 943, division 007;

(c) Lacks the skills, knowledge, or ability to perform or learn to perform the required work;

(d) Violates the protective service and abuse rules in OAR chapter 411, division 20, OAR chapter 407, division 45, and OAR chapter 943, division 45;

(e) Commits fiscal improprieties;

(f) Fails to provide the authorized services required by an eligible individual;

(g) Has been repeatedly late in arriving to work or has absences from work not authorized in advance by an individual;

(h) Has been intoxicated by alcohol or drugs while providing authorized services to an individual or while in the individual’s home;

(i) Has manufactured or distributed drugs while providing authorized services to an individual or while in the individual’s home; or

(j) Has been excluded as a provider by the U.S. Department of Health and Human Services, Office of Inspector General from participation in Medicaid, Medicare, or any other federal health care programs.

(3) A personal support worker may contest the Authority’s decision to terminate the personal support worker’s provider enrollment and provider number:

(a) A designated employee from the Authority shall review the termination and notify the personal support worker of the decision;

(b) A personal support worker may file a request for a hearing with the Authority’s local office if all levels of administrative review have been exhausted and the
provider continues to dispute the Authority’s decision. The local office shall file the request for a hearing with the Office of Administrative Hearings as described in OAR chapter 137, division 3. The request for a hearing shall be filed within 30 calendar days of the date of the written notice from the Authority;

(c) When a contested case is referred to the Office of Administrative Hearings, the referral shall indicate whether the Authority is authorizing a proposed order, a proposed and final order, or a final order;

(d) No additional hearing rights have been granted to a personal support worker by this rule other than the right to a hearing on the Authority’s decision to terminate provider enrollment.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0830 – Personal care attendant Service Assessment, Authorization, and Monitoring

(1) A behavioral health case manager shall meet in person with an individual to assess the individual’s ability to perform the personal care tasks listed in this rule:

(a) An individual’s natural supports may participate in the assessment if requested by the individual;

(b) A behavioral health case manager shall assess an individual’s service needs, identify the resources meeting any, some, or all of the individual’s needs and determine if the individual is eligible for behavioral health personal care attendant services or other services;

(c) A behavioral health case manager shall meet with an individual in person at least once every 365 days to review the individual’s service needs.

(2) A behavioral health case manager shall prepare a service plan identifying the tasks for which an individual requires assistance and the number of monthly authorized service hours. The case manager shall document an individual’s natural supports that currently meet some or all of the individual’s assistance needs:

(a) The service plan shall describe the tasks to be performed by a qualified provider and shall authorize the maximum monthly hours that may be reimbursed for those services;

(b) A case manager shall consider the cost effectiveness of services that adequately meet the individual’s service needs when developing service plans;

(c) Payment for behavioral health personal care attendant services shall be prior authorized by a behavioral health case manager and based on the service needs of an individual as documented in the individual’s written service plan.

(3) When there is an indication that an individual’s personal care needs have changed, a case manager shall conduct an in-person reassessment with the individual and any of the individual’s natural supports if requested by the individual:

(a) Following annual reassessments and those conducted after a change in an individual’s personal care needs, a case manager shall review service eligibility, the cost effectiveness of the individual’s service plan, and whether the services provided are meeting the individual’s identified service needs;

(b) The case manager may adjust the hours or services in the individual’s service plan and shall authorize a new service plan, if appropriate, based on the individual’s current service needs.
(4) A behavioral health case manager shall provide ongoing coordination of behavioral health personal care attendant services, including authorizing changes in providers and service hours, addressing risks, and monitoring and providing information and referral to an individual when indicated.

(5) The Authority may not authorize services within an eligible individual's home when:

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

(b) The services cannot be provided safely or adequately by a provider;

(c) The individual does not have the ability to make an informed decision, does not have a designated representative to make decisions on his or her behalf, and necessary safeguards cannot be provided to protect the individual’s safety, health, and welfare.

(6) A behavioral health case manager shall present an individual or the individual's representative with information on service alternatives and provide assistance to assess other choices when a provider or service setting selected by the individual or the individual's representative is not authorized.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0840 – Personal Care Attendant Payment Limitations

(1) The number of behavioral health personal care attendant service hours authorized for an individual per calendar month is based on projected amounts of time to perform specific personal care and supportive services to the eligible individual. The total of these hours are limited to 20 hours per individual per month. Individuals whose assessed service needs exceed the 20 hour limit may receive approval for additional hours.

(2) The Authority shall pay for behavioral health personal care attendant services when all acceptable provider enrollment standards have been verified and both the employer and provider have been formally notified in writing that payment by the Authority is authorized.

(3) In accordance with OAR 410-120-1300, all provider claims for payment shall be submitted within 12 months of the date of service.

(4) Payment may not be claimed by a provider until the hours authorized for the payment period have been completed, as directed by an eligible individual or the individual’s representative.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
410-172-0850 - Telemedicine for Behavioral Health

(1) Telemedicine encompasses different types of programs, services, and delivery mechanisms for medically appropriate covered services within the recipient’s benefit package:

(a) Patient consultations using telephone and online or electronic mail (e-mail) are covered when billed services comply with the practice guidelines set forth by the Health Evidence Review Commission and the applicable HERC-approved code requirements, delivered consistent with the HERC Evidence-Based Guidelines;

(b) Patient consultations using videoconferencing, a synchronous (live two-way interactive) video transmission resulting in real time communication between a provider located in a distant site and the recipient being evaluated and located in an originating site, is covered when billed services comply with the billing requirements stated below.

(2) Behavioral health services specifically identified as allowable for telephonic delivery are listed on the Behavioral Health Fee schedule published by the Authority.

(3) Unless expressly authorized in OAR 410-120-1200 (Exclusions), other types of telecommunications are not covered such as images transmitted via facsimile machines and electronic mail when:

(a) Those methods are not being used in lieu of videoconferencing, due to limited videoconferencing equipment access; or

(b) Those methods and specific services are not specifically allowed pursuant to the Oregon Health Evidence Review Commission’s Prioritized List of Health Services and Evidence Based Guidelines.

(4) Providers billing for covered telemedicine services shall:

(a) Comply with HIPAA and the Authority’s Confidentiality and Privacy Rules and security protections for the patient in connection with the telemedicine communication and related records;

(b) Obtain and maintain technology used in the telemedicine communication that is compliant with privacy and security standards in HIPAA and the Authority’s Privacy and Confidentiality Rules set forth in OAR 943 division 14;

(c) Ensure policies and procedures are in place to prevent a breach in privacy or exposure of patient health information or records (whether oral or recorded in any form or medium) to unauthorized individuals;
Behavior Health Services Rules

(d) Comply with the relevant HERC evidence-based guidelines for telephone and e-mail consultation. Refer to the current prioritized list and evidence based guidelines at http://www.oregon.gov/oha/herc/Pages/PrioritizedList.aspx;

(e) Maintain clinical and financial documentation related to telemedicine services as required in OAR 410-120-1360.

(5) For purposes of behavioral health services, the Authority shall provide coverage for telemedicine services to the same extent that the services would be covered if they were provided in person.

Stat. Auth.: ORS 413.042 & 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705 & 430.715
410-172-0860 – Billing for Dual Eligible Individuals

(1) As described in OAR 410-120-1280 (8), when an individual has both Medicare and coverage through Medicaid, providers shall make reasonable efforts to obtain payment from other resources including Medicare or other Third Party Liability (TPL).

(2) In accordance with OAR 410-120-1280 (f), OAR 410-141-0420, and OAR 410-141-3420, behavioral health providers may bill the Division directly and may not be required to bill Medicare under the following circumstances:

(a) For behavioral health services that are never covered by Medicare or another insurer;

(b) For behavioral health services that are not covered when rendered by the following provider types:

   (A) Qualified Mental Health Professional (non-licensed) as defined in OAR 309-019-0105;

   (B) Qualified Mental Health Associate as defined in OAR 309-019-0105;

   (C) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

   (D) Certified Peer Support Specialist as defined in OAR 410-180-0305;

   (E) Recovery Assistant;

   (F) Certified Alcohol and Drug Counselor.

Stat. Auth.: ORS 413.042, 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, 430.715
Behavior Health Services Rules

The Division has repealed the following rule from the division 172 Behavior Health Rules. This means that the rule is no longer in effect as of November 26th, 2019:

Repealed 410-172-0700 – 1915(i) Home and Community-Based Services

(1) Habilitation services are designed to help an individual attain or maintain their maximal level of independence, including the individual’s acceptance of a current residence and the prevention of unnecessary changes in residence. Services are provided in order to assist an individual to acquire, retain, or improve skills in one or more of the following areas: Assistance with activities of daily living, cooking, home maintenance, community inclusion and mobility, money management, shopping, community survival skills, communication, self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

(2) Psychosocial rehabilitation services are medical or remedial services recommended by a licensed physician or other licensed practitioner to reduce impairment to an individual’s functioning associated with the symptoms of a mental disorder or to restore functioning to the highest degree possible.

(3) Paid providers of 1915(i) services shall meet one of the following qualifications:

   (a) Physician or Physician Assistant licensed by the Oregon Medical Board;

   (b) Advanced Practice Nurse including Clinical Nurse Specialist and Certified Nurse Practitioner licensed by the Oregon Board of Nursing;

   (c) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;

   (d) Clinical Social Worker licensed by the Oregon Board of Licensed Social Workers;

   (e) Psychologist licensed by the Oregon Board of Psychology;

   (f) Residential treatment home or facility licensed pursuant to OAR chapter 309, division 035;

   (g) Adult Foster Home licensed pursuant to OAR chapter 309, division 040;

   (h) Certificate issued by AMH pursuant to OAR chapter 309, division 012;

(4) Non-paid providers shall be employed or subcontracted with a provider licensed or certified by AMH and meet one of the following qualifications:

   (a) Qualified Mental Health Professional as defined in OAR 309-019-0105;

   (b) Qualified Mental Health Associate as defined in OAR 309-019-0105;
(c) Mental Health Intern as defined in OAR 309-019-0105;

(d) Peer-Support Specialist as defined in OAR 410-180-0305;

(e) Recovery Assistant.

(5) Providers of 1915(i) services may be required to meet Community Mental Health Program (CMHP) liability insurance requirements.

(6) Due to federal requirements for the Authority to ensure the impartiality of paid providers rendering services to 1915(i) eligible members, providers may be restricted from conducting eligibility reviews or developing the behavioral health assessment or service plan.

(7) To be eligible for services under the 1915(i) State Plan HCBS, the individual shall meet the following requirements:

(a) Been diagnosed with a chronic mental illness as defined in ORS 426.495;

(b) Been assessed as needing assistance to perform at least two personal care services as identified in these rules due to a chronic mental illness.

(8) Eligibility for 1915(i) services is determined by an external Quality Improvement Organization (QIO) as identified by the Division.

Stat. Auth.: ORS 413.042 and 430.640

Stats. Implemented: ORS 413.042, 414.025, 414.065, 430.640, 430.705, and 430.715