Secretary of State

NOTICE OF PROPOSED RULEMAKING HEARING*

A Statement of Need and Fiscal Impact accompanies this form.

Department of Human Services, Developmental Disabilities	411
Agency and Division	Administrative Rules Chapter Number

Kimberly Colkitt-Hallman	500 Summer Street NE, E-48 Salem, OR 97301-1074	(503) 945-6398
Rules Coordinator	Address	Telephone

RULE CAPTION

ODDS: Agency Certification and Endorsement - Medicaid Provider Enrollment Requirements

Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

May 19, 2016	1:30 p.m.	Human Services Building 500 Summer Street NE, Rm. 160 Salem, Oregon 97301	Staff
Hearing Date	Time	Location	Hearings Officer

Auxiliary aids for persons with disabilities are available upon advance request.

RULEMAKING ACTION

Secure approval of new rule numbers (Adopted or Renumbered rules) with the Administrative Rules Unit prior to filing.

ADOPT:

411-323-0065

AMEND:

OAR chapter 411, divisions 323 and 370

REPEAL:

Temporary Rules: 411-323-0010(T); 411-323-0020(T); 411-323-0030(T); 411-323-0035(T); 411-323-0060(T); 411-370-0010(T)

Stat. Auth.: ORS 409.050, 410.070, 411.060, 430.640

Other Auth.:

Stats. Implemented: ORS 409.050, 427.005, 427.007, 430.215, 430.610-695, 443.400-455

RULE SUMMARY

The Department of Human Services, Office of Developmental Disabilities Services (Department) is proposing to update the rules in --

- OAR chapter 411, division 323 for agency certification and endorsement to provide developmental disabilities services in community-based settings; and
- OAR chapter 411, division 370 for Medicaid provider enrollment requirements.

The rules in OAR chapter 411, division 323 are being amended to --

- Make permanent temporary changes that became effective on January 1, 2016;
- Remove general definitions included in OAR 411-317-0000;
- Demonstrate the Department's commitment to the Employment First Policy by assuring that only agencies that have a current endorsement are able to deliver employment services under OAR chapter 411, division 345;
- Provide for a two year phase-in period for certification of agencies previously certified under OAR chapter 411, division 340;
- Require endorsement to the rules in OAR chapter 411, division 323 and corresponding program rules when an agency was previously able to deliver attendant care or employment services under a different endorsement or was certified under OAR chapter 411, division 340. This requirement will be phased in over a two year period;
- Change the certification and endorsement periods from five to two years;
- Adopt the standards for home and community-based (HCB) services and settings and person-centered service planning adopted by the Department in OAR chapter 411, division 004 on January 1, 2016;
- Incorporate a new requirement that agency certification and endorsement is contingent upon meeting the standards for HCB services and settings and person-centered service planning in OAR chapter 411, division 004;
- Include correct references to OAR chapter 411, division 318 for individual rights to ensure uniform standards related to individual rights across all types of entities involved in the delivery of developmental disabilities services;
- Establish an alternate fiscal auditing standard for agencies with less than $1,000,000 revenue per fiscal year;
- Include current Medicaid and Department standards for reimbursement for the delivery of developmental disabilities services; and
- Reflect current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.

The rules in OAR chapter 411, division 370 are being amended to --

- Require agencies endorsed to operate a Community Living Support Program under OAR chapter 411, division 450 to acquire a Medicaid provider number and meet the associated provider enrollment requirements; and

- Reflect current Department terminology, identify that Support Services Brokerages authorize developmental disabilities services, and perform minor grammar, punctuation, formatting, and housekeeping changes.

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

Written comments may be submitted via e-mail to Kimberly.Colkitt-Hallman@state.or.us or mailed to 500 Summer Street NE, E48 Salem, Oregon, 97301-1064. All comments received will be given equal consideration before the Department proceeds with the permanent rulemaking.

May 23, 2016 at 5:00 p.m.
Last Day for Public Comment (Last day to submit written comments to the Rules Coordinator)

Secretary of State

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Department of Human Services, Developmental Disabilities 411

Agency and Division | Administrative Rules Chapter Number

ODDS: Agency Certification and Endorsement - Medicaid Provider Enrollment Requirements

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: The adoption of OAR 411-323-0065; amendment of OAR chapter 411, divisions 323 and 370; and repeal of temporary OAR 411-323-0010(T); 411-323-0020(T); 411-323-0030(T); 411-323-0035(T); 411-323-0060(T); and 411-370-0010(T) relating to agency certification and endorsement and related Medicaid provider enrollment requirements.

Statutory Authority:
ORS 409.050, 410.070, 411.060, 430.640

Other Authority:

Stats. Implemented:
ORS 409.050, 427.005, 427.007, 430.215, 430.610-695, 443.400-455

Need for the Rule(s):
The Department needs to amend the rules in OAR chapter 411, division 323 to --

- Make permanent temporary changes that became effective on January 1, 2016;
- Streamline definitions;
- Assure qualified providers are delivering services;
- Change the certification and endorsement periods from five to two years;
- Implement the regulations and expectations of CMS for residential and non-residential HCB services and settings and person-centered service planning;
- Ensure uniform standards related to individual rights across all types of entities involved in the delivery of developmental disabilities services;
- Establish an alternate fiscal auditing standard for agencies with less than $1,000,000 revenue per fiscal year;
- Assure payment is made in compliance with state and federal standards and regulations; and
- Reflect current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.

The rules in OAR chapter 411, division 323 are being amended to --

- Make permanent temporary changes that became effective on January 1, 2016;
- Remove general definitions included in OAR 411-317-0000;
- Demonstrate the Department's commitment to the Employment First Policy by assuring that only agencies that have a current endorsement are able to deliver employment services under OAR chapter 411, division 345;
- Provide for a two year phase-in period for certification of agencies previously certified under OAR chapter 411, division 340;
- Require endorsement to the rules in OAR chapter 411, division 323 and corresponding program rules when an agency was previously able to deliver attendant care or employment services under a different endorsement or was certified under OAR chapter 411, division 340. This requirement will be phased in over a two year period;
- Change the certification and endorsement periods from five to two years;
- Adopt the standards for HCB services and settings and person-centered service planning adopted by the Department in OAR chapter 411, division 004 on January 1, 2016;
- Incorporate a new requirement that agency certification and endorsement is contingent upon meeting the standards for HCB services and settings and person-centered service planning in OAR chapter 411, division 004;
- Incorporate references to the rules for individual rights in OAR chapter 411, division 318;
- Establish an alternate fiscal auditing standard for agencies with less than $1,000,000 revenue per fiscal year;
- Include current Medicaid and Department standards for reimbursement for the delivery of developmental disabilities services; and
- Reflect current Department terminology, and perform minor grammar, punctuation, formatting, and housekeeping changes.

The Department needs to amend the rules in OAR chapter 411, division 370 to --

- Require a certified and endorsed agency to acquire a Medicaid provider number and meet the associated provider enrollment requirements; and
- Reflect current Department terminology and identify that Support Services Brokerages authorize developmental disabilities services.

The rules in OAR chapter 411, division 370 are being amended to --

- Require agencies endorsed to operate a Community Living Support Program under OAR chapter 411, division 450 to acquire a Medicaid provider number and meet the associated provider enrollment requirements; and

- Reflect current Department terminology, identify that Support Services Brokerages authorize developmental disabilities services, and perform minor grammar, punctuation, formatting, and housekeeping changes.

Documents Relied Upon, and where they are available:

Fiscal and Economic Impact:
Statement of Cost of Compliance:
1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):
The Department estimates that amending OAR chapter 411, divisions 323 and 370 will have the following fiscal and economic impact:

State Agencies: Changing the certification and endorsement period from five to two years will have a proportional increase (2.5 times greater) on the workload for the Office of Licensing and Regulatory Oversight.

Units of Local Government: The Department estimates there will be no fiscal or economic impact on Community Developmental Disabilities Programs (CDDPs) or Support Services Brokerages (Brokerages) because the proposed rule changes do not directly impact the CDDPs or Support Services Brokerages.

Individuals Receiving Services: The Department estimates there will be no fiscal or economic impact on individuals receiving services because the proposed rule changes do not directly impact individuals receiving services.

Providers: Current agency providers certified under OAR chapter 411, division 340 or certified under OAR chapter 411, division 323 and endorsed under a corresponding program rule, will require a new endorsement under OAR chapter 411, division 450 (Community Living Supports) upon expiration of their current agency certification.

Agency providers that do not currently have the requirement for their staff to have 12 hours of job related in-service training annually, and do not have existing policies and procedures that address the expectations set forth in OAR chapter 411, division 450 for operating a Community Living Supports Program will likely have some costs associated to meeting those requirements. The Department is unable to estimate the number of agencies or staff at each agency that may require training. The Department also is unable to estimate the number of providers that will need to update policies to comply with the rules or the costs associated with those updates as they will vary by provider.

Public: The Department estimates there will be no fiscal or economic impact on the public because the proposed rule changes do not directly impact individuals receiving services.

2. Cost of compliance effect on small business (ORS 183.336):
a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:
The Department estimates that there are approximately 248 agencies that contract to provide Medicaid developmental disabilities services in Oregon, some of which may be considered a small businesses as defined in ORS 183.310.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:
The impact is described above in the Department's statement of cost of compliance.

c. Equipment, supplies, labor and increased administration required for compliance:
The impact is described above in the Department's statement of cost of compliance.

How were small businesses involved in the development of this rule?
A small business as defined in ORS 183.310 participated on the Administrative Rule Advisory Committee. Small businesses will also be included in the public review and comment period.

Administrative Rule Advisory Committee consulted?:
Yes. The Administrative Rule Advisory Committee included representation from: Partners in Community Living; Support Service Brokerages; Service Employees International Union; Oregon Home Care Commission; Dungarvin, Inc.; CDDPs; and Oregon Rehabilitation Association.

Signed Lilia Teninty, Director, Developmental Disabilities 4/15/2016
Signature Date

DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 323

AGENCY CERTIFICATION AND ENDORSEMENT TO PROVIDE ~~SERVICES TO INDIVIDUALS WITH INTELLECTUAL OR~~ DEVELOPMENTAL DISABILITIES SERVICES IN COMMUNITY-BASED SETTINGS

411-323-0010 Statement of Purpose

(1) The rules in OAR chapter 411, division 323 prescribe standards, responsibilities, and procedures for agencies to obtain a certificate and endorsement in order to ~~provide~~operate a program that delivers person-centered services to individuals with intellectual or developmental disabilities in a community-based ~~service~~ setting as described in:

(a) OAR chapter 411, division 325 for 24-hour residential ~~settings~~programs;

(b) OAR chapter 411, division 328 for supported living ~~settings~~programs; ~~and~~

(c) OAR chapter 411, division 345 for employment~~.~~ supports;

(d) OAR chapter 411, division 450 for community living supports.

(2) To ~~provide~~operate a program described in section (1) of this rule that delivers person-centered services to individuals with intellectual or developmental disabilities ~~in the community-based service settings described in section (1) of this rule~~, agencies must have:

(a) A certificate to provide Medicaid services in the state of Oregon as described in OAR 411-323-0030;

(b) Endorsement for each ~~service setting~~developmental disabilities program type as described in OAR 411-323-0035;

(c) A Medicaid Agency Identification Number assigned by the Department as described in OAR chapter 411, division 370; and

(d) For each licensed site or geographic location where direct services are to be delivered, a Medicaid Performing Provider Number assigned by the Department as described in OAR chapter 411, division 370.

(e) Section (2) of this rule does not apply to an agency delivering community living supports that was certified, or that has applied for certification, according to OAR 411-340-0170 prior to January 1, 2016, until that organization requires renewal of its certification according to OAR 411-340-0030.

Stat. Auth. ORS 409.050
Stats. Implemented: ORS 409.050

411-323-0020 Definitions

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 323:

~~(1) "24-Hour Residential Setting" means a comprehensive residential home licensed by the Department under ORS 443.410 to provide residential care and training to individuals with intellectual or developmental disabilities.~~

~~(2) "Abuse" means:~~

~~(a) For a child:~~

~~(A) "Abuse" as defined in ORS 419B.005; and~~

~~(B) "Abuse" as defined in OAR 407-045-0260 when a child resides in a 24-hour residential setting licensed by the Department as described in OAR chapter 411, division 325.~~

~~(b) For an adult, "abuse" as defined in OAR 407-045-0260.~~

~~(3) "Abuse Investigation" means the reporting and investigation activities as required by OAR 407-045-0300 and any subsequent services or supports necessary to prevent further abuse as required by OAR 407-045-0310.~~

~~(4) "Adult" means an individual who is 18 years or older with an intellectual or developmental disability.~~

~~(5) "Agency" means a public or private community agency or organization that is approved by the Department to provide services to individuals with intellectual or developmental disabilities in a community-based service setting.~~

(1~~6~~) "Applicant" means a person, agency, corporation, or governmental unit who applies for certification and endorsement to operate an agency ~~providing~~delivering services to individuals with intellectual or developmental disabilities ~~in a community-based service setting~~.

(2~~7~~) "Audit" means an inspection completed by a Certified Public Accountant using standards and accepted practices of accounting activities to ensure all state and federal funds are expended for the purpose the funds were contracted and intended for without fraudulent activity.

(3~~8~~) "Audit Review" means a Certified Public Accountant, without applying comprehensive audit procedures, assesses the standards and accepted practices of accounting activities and ensures the accounting activities are in conformity with generally accepted accounting principles.

(4~~9~~) "Board of Directors" means the group of people formed to set policy and give directions to an agency designed to provide services to individuals with intellectual or developmental disabilities ~~in a community-based service setting.~~. A board of directors may include local advisory boards used by multi-state organizations.

~~(10) "CDDP" means "community developmental disability program" as defined in OAR 411-320-0020.~~

(~~11~~5) "Certificate" means the document issued by the Department to an agency that certifies the agency is eligible to receive state funds for the ~~provision~~delivery of services in an endorsed ~~service setting~~program.

~~(12) "Chemical Restraint" means the use of a psychotropic drug or other drugs for punishment or to modify behavior in place of a meaningful behavior or treatment plan.~~

~~(13) "Child" means an individual who is less than18 years of age that has a provisional determination of an intellectual or developmental disability.~~

~~(14) "Choice" means the expression of preference, opportunity for, and active role of an individual in decision-making related to services received and from whom including, but not limited to, case management, providers, services, and service settings. Individuals are supported in opportunities to make changes when so expressed. Choice may be communicated through a variety of methods, including orally, through sign language, or by other communication methods.~~

~~(15) "Complaint" means "complaint" as defined in OAR 411-318-0005.~~

~~(16) "Complaint Investigation" means the investigation of a complaint that has been made to a proper authority that is not covered by an abuse investigation.~~

~~(17) "Condition" means a provision attached to:~~

~~(a) A new or existing certificate that limits or restricts the scope of the certificate or imposes additional requirements on the certified agency; or~~

~~(b) A new or existing endorsement that limits or restricts the scope of program services or imposes additional requirements on the certified agency.~~

(6~~18~~) "Denial" means the refusal of the Department to issue:

(a) A certificate to operate an agency because the Department has determined the agency is not in compliance with these rules or the corresponding program rules; or

(b) An endorsement for an agency to ~~provide~~operate a program ~~services~~ because the Department has determined the agency is not in compliance with these rules or the corresponding program rules.

~~(19) "Department" means the Department of Human Services.~~

~~(20) "Designated Representative" means any adult, such as a parent, family member, guardian, advocate, or other person, who is chosen by an individual or the legal representative of the individual, not a paid provider for the individual, and authorized by the individual or the legal representative of the individual to serve as the representative of the individual or the legal representative of the individual in connection with the provision of funded supports. An individual or a legal representative of the individual is not required to appoint a designated representative.~~

~~(21) "Developmental Disability" means "developmental disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.~~

~~(22) "Director" means the Director of the Department of Human Services, Office of Developmental Disability Services or Office of Licensing and Regulatory Oversight, or the designee of the Director.~~

(~~23~~7) "Endorsement" means the authorization to ~~provide~~operate a program that delivers services. An endorsement is issued by the Department to a certified agency that has met the qualification criteria outlined in these rules and the corresponding program rules.

(~~24~~8) "Executive Director" means the person designated by a board of directors or corporate owner of an agency that is responsible for the administration of the services ~~provided~~delivered by the agency.

~~(25) "Founded Report" means the determination by the Department or Law Enforcement Authority, based on the evidence, that there is reasonable cause to believe that conduct in violation of the child abuse statutes or rules has occurred and such conduct is attributable to the person alleged to have engaged in the conduct.~~

~~(26) "Guardian" means the parent for an individual less than 18 years of age or the person or agency appointed and authorized by a court to make decisions about services for an individual.~~

~~(27) "Independence" means the extent to which an individual exerts control and choice over his or her own life.~~

~~(28) "Individual" means a child or an adult with an intellectual or developmental disability applying for, or determined eligible for Department-funded services. Unless otherwise specified, references to individual also include the legal or designated representative of the individual, who has the ability to act for the individual and exercise the rights of the individual.~~

(~~2~~9) "Informal Conference" means the discussion between the Department and an applicant or an agency that is held prior to a hearing to address any matters pertaining to the hearing. An administrative law judge does not participate in an informal conference. The informal conference may result in resolution of the issue.

~~(30) "Integration" as defined in ORS 427.005 means:~~

~~(a) Use by individuals with intellectual or developmental disabilities of the same community resources used by and available to other people;~~

~~(b) Participation by individuals with intellectual or developmental disabilities in the same community activities in which people without disabilities participate, together with regular contact with people without disabilities; and~~

~~(c) Residence by individuals with intellectual or developmental disabilities in homes or home-like settings that are in proximity to community resources, together with regular contact with people without disabilities in their community.~~

~~(31) "Intellectual Disability" means "intellectual disability" as defined in OAR 411-320-0020 and described in OAR 411-320-0080.~~

~~(32) "ISP" means "Individual Support Plan". An ISP includes the written details of the supports, activities, and resources required for an individual to achieve and maintain personal goals and health and safety. The ISP is developed at least annually to reflect decisions and agreements made during a person-centered process of planning and information gathering that is driven by the individual. The ISP reflects services and supports that are important for the individual to meet the needs of the individual identified through a functional needs assessment as well as the preferences of the individual for providers, delivery, and frequency of services and supports. The ISP is the plan of care for Medicaid purposes and reflects whether services are provided through a waiver, the Community First Choice state plan, natural supports, or alternative resources.~~

~~(33) "ISP Team" means a team composed of an individual receiving services and the legal or designated representative of the individual (as applicable), services coordinator, and others chosen by the individual, such as providers and family members.~~

~~(34) "Legal Representative" means a person who has the legal authority to act for an individual.~~

> ~~(a) For a child, the legal representative is the parent of the child unless a court appoints another person or agency to act as the guardian of the child.~~
>
> ~~(b) For an adult, the legal representative is the attorney at law who has been retained by or for the adult, the power of attorney for the adult, or the person or agency authorized by a court to make decisions about services for the adult.~~

~~(35) "Mandatory Reporter":~~

> ~~(a) Means any public or private official as defined in OAR 407-045-0260 who:~~
>
> > ~~(A) Comes in contact with a child with or without an intellectual or developmental disability and has reasonable cause to believe the child has suffered abuse, or comes in contact with any person whom the public or private official has reasonable~~

~~cause to believe abused a child, regardless of whether or not the knowledge of the abuse was gained in the official capacity of the public or private official.~~

~~(B) While acting in an official capacity, comes in contact with an adult with an intellectual or developmental disability and has reasonable cause to believe the adult has suffered abuse, or comes in contact with any person whom the public or private official has reasonable cause to believe abused an adult.~~

~~(b) Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this definition, except that a psychiatrist, psychologist, clergy, attorney, or guardian ad litem appointed under ORS 419B.231 is not required to report if the communication is privileged under ORS 40.225 to 40.295.~~

~~(36) "Mechanical Restraint" means any mechanical device, material, object, or equipment attached or adjacent to the body of an individual that the individual cannot easily remove or easily negotiate around and that restricts freedom of movement or access to the body of the individual.~~

~~(37) "Medicaid Agency Identification Number" means the numeric identifier assigned by the Department to an agency following the enrollment of the agency as described in OAR chapter 411, division 370.~~

~~(38) "Medicaid Performing Provider Number" means the numeric identifier assigned by the Department to an entity or person following the enrollment of the entity or person to deliver Medicaid funded services as described in OAR chapter 411, division 370. The Medicaid Performing Provider Number is used by the rendering provider for identification and billing purposes associated with service authorizations and payments.~~

~~(39) "OIS" means "Oregon Intervention System". OIS is the system of providing training of elements of positive behavior support and non-aversive behavior intervention. OIS uses principles of pro-active support and describes approved protective physical intervention techniques that are used to maintain health and safety.~~

(410) "Ownership Interest" means, as defined in 42 CFR 455.101, the possession of equity in the capital, the stock, or the profits of the disclosing

entity as determined by 42 CFR 455.102. A person with an ownership or control interest means a person or corporation that:

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

~~(41) "Person-Centered Planning":~~

~~(a) Means a timely and formal or informal process driven by an individual, includes people chosen by the individual, ensures the individual directs the process to the maximum extent possible, and the individual is enabled to make informed choices and decisions consistent with 42 CFR 441.540.~~

~~(b) Person-centered planning includes gathering and organizing information to reflect what is important to and for the individual and to help:~~

~~(A) Determine and describe choices about personal goals, activities, services, providers, service settings, and lifestyle preferences;~~

~~(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using individual strengths, relationships, and resources; and~~

~~(C) Identify, use, and strengthen naturally occurring opportunities for support at home and in the community.~~

~~(c) The methods for gathering information vary, but all are consistent with the cultural considerations, needs, and preferences of the individual.~~

~~(42) "Positive Behavioral Theory and Practice" means a proactive approach to behavior and behavior interventions that:~~

~~(a) Emphasizes the development of functional alternative behavior and positive behavior intervention;~~

~~(b) Uses the least intrusive intervention possible;~~

~~(c) Ensures that abusive or demeaning interventions are never used; and~~

~~(d) Evaluates the effectiveness of behavior interventions based on objective data.~~

~~(43) "Productivity" as defined in ORS 427.005 means regular engagement in income-producing work, preferable competitive employment with supports and accommodations to the extent necessary, by an individual that is measured through improvements in income level, employment status, or job advancement or engagement by an individual in work contributing to a household or community.~~

(11~~44~~) "Program Rules" mean the rules in:

(a) OAR chapter 411, division 325 for 24-hour residential ~~settings~~programs;

(b) OAR chapter 411, division 328 for supported living ~~settings~~programs; ~~and~~

(c) OAR chapter 411, division 345 for employment~~.~~ supports; and

(d) OAR chapter 411, division 450 for community living supports.

(4~~5~~12) "Program ~~Services~~" mean~~s~~ the ~~person-centered~~ services ~~provided~~ in~~d~~elivered by a ~~community-based setting~~provider agency ~~-~~as described in:

(a) OAR chapter 411, division 325 for 24-hour residential ~~settings~~programs;

(b) OAR chapter 411, division 328 for supported living ~~settings~~programs;~~ and~~

(c) OAR chapter 411, division 345 for employment~~.~~ programs; and

(d) OAR chapter 411, division 450 for community living programs.

~~(46) "Protective Services" mean the necessary actions offered to an individual as soon as possible to prevent subsequent abuse or exploitation of an individual, to prevent self-destructive acts, and to safeguard the person, property, and funds of the individual.~~

~~(47) "Protective Physical Intervention" means any manual physical holding of, or contact with, an individual that restricts freedom of movement.~~

~~(48) "Provider" means a public or private community agency or organization that provides recognized developmental disability services and is certified and endorsed by the Department to provide these services under these rules and the rules in OAR chapter 411, division 323.~~

(13~~49~~) "Revocation" means the action taken by the Department to rescind:

(a) A certificate to operate an agency after the Department has determined that the agency is not in compliance with these rules or the corresponding program rules; or

(b) An endorsement for an agency to ~~provide~~operate a program ~~services~~ after the Department has determined that the agency is not in compliance with these rules or the corresponding program rules.

~~(50) "Services Coordinator" means "services coordinator" as defined in OAR 411-320-0020.~~

~~(51) "Service Setting" means the community-based settings as described in:~~

~~(a) OAR chapter 411, division 325 for 24-hour residential settings;~~

~~(b) OAR chapter 411, division 328 for supported living settings; and~~

~~(c) OAR chapter 411, division 345 for employment.~~

~~(52) "Staff" means a paid employee responsible for providing services to an individual whose wages are paid in part or in full with funds sub-contracted with the CDDP or contracted directly through the Department.~~

~~(53) "Substantiated" means an abuse investigation has been completed by the Department or the designee of the Department and the preponderance of the evidence establishes the abuse occurred.~~

(~~5~~1~~4~~) "Suspension" means an immediate temporary withdrawal of the:

(a) Certificate to operate an agency after the Department determines that the agency is not in compliance with these rules or the corresponding program rules; or

(b) Endorsement for an agency to ~~provide~~operate a program ~~services~~ after the Department determines that the agency is not in compliance with these rules or the corresponding program rules.

(~~5~~1~~5~~) "These Rules" mean the rules in OAR chapter 411, division 323.

~~(56) "Unacceptable Background Check" means an administrative process that produces information related to the background of an agency that precludes the agency from being certified or endorsed for one or more of the following reasons:~~

~~(a) Under OAR 407-007-0275, the agency or any person holding 5 percent or greater ownership interest in the agency has been found ineligible due to ORS 443.004; or~~

~~(b) A background check and fitness determination has been conducted resulting in a "denied" status as defined in OAR 407-007-0210.~~

(16~~57~~) "Variance" means a temporary exception from a regulation or provision of these rules that may be granted by the Department upon written application by the agency.

Stat. Auth. ORS 409.050
Stats. Implemented: ORS 409.050

411-323-0030 Certification

(1) CERTIFICATION. Except for an agency with a current certification, or that has applied for certification, according to OAR 411- 340-0140 prior to January 1, 2016, a person, agency, or governmental unit acting individually or jointly with any other person, agency, or governmental unit intending to ~~provide~~operate a program ~~services~~ as defined in OAR 411-323-0020 must be certified by the Department under these rules before establishing, conducting, maintaining, managing, or operating an agency.

(a) Certificates are not transferable.

(b) The Department issues or renews a certificate to an agency found to be in compliance with these rules, the rules in OAR chapter 411, division 004, and the corresponding program rules. The certificate is effective for ~~five~~two years from the date issued unless sooner revoked or suspended.

(c) If an agency fails to provide complete, accurate, and truthful information during the application or renewal process, the Department may delay initial certification, deny the application, or revoke or refuse to renew the application for certification.

(d) For the purpose of certification, any applicant or person with an ownership interest in an agency is considered responsible for acts occurring during, and relating to, the operation of the agency.

(e) The Department may consider the background and operating history of the applicant and each person with an ownership interest when determining whether to issue or renew a certificate.

(f) A review of the agency is conducted by the Department prior to the issuance or renewal of a certificate.

(2) CURRENT AGENCY CERTIFICATION.

(a) Within 2 years of January 1, 2016, all agency certification must be renewed as described in section (4) of this rule.

(b) All agencies ~~providing program services~~, as of July 1, ~~2011~~2016, are certified for ~~five~~two years unless the certificate is sooner revoked or suspended.

(~~b~~c) Agencies licensed or certified under OAR chapter 411, division 054 for residential care and assisted living facilities, OAR chapter 309, division 035 for residential treatment facilities for people who are mentally or emotionally disturbed, OAR chapter 413, division 215 for child welfare private child caring agencies, or OAR chapter 416, division 550 for youth offender treatment foster care, and as may be described in corresponding program rules, do not require additional certification as an agency under these rules to ~~provide program~~ deliver services. Current license or certification is considered sufficient demonstration of ability to:

(A) Recruit, hire, supervise, and train qualified staff;

(B) ~~Provide~~Deliver services according to an ISP; and

(C) Develop and implement operating policies and procedures required for managing an agency and delivering services, including provisions for safeguarding individuals receiving services.

(3) INITIAL CERTIFICATION. Notwithstanding section (2) of this rule, an applicant intending to provide program services as defined in OAR 411-323-0020 must apply for an initial certificate and demonstrate to the satisfaction of the Department that the applicant is in compliance with these rules, the rules in OAR chapter 411, division 004, and the corresponding program rules.

(a) The applicant must submit an application to the Department at least 90 days prior to the proposed date of ~~provision~~delivery of ~~program~~ services to individuals. The completed application must be on a form provided by the Department and must include all information requested by the Department.

(b) At a minimum, the applicant must provide:

(A) A copy of any management agreements or contracts relative to the operation and ownership of the agency;

(B) A financial plan that includes financial statements indicating capital and the financial plan developed to assure sustainability, partnerships, loans, and any other financial assistance; ~~or~~ and

(C) As required by 42 CFR 455.104, the name, date of birth, and social security number for each person currently serving as the Board of Directors for the agency, and as changes are made.

(c) The applicant must develop a plan identifying the scope of ~~program~~ services the applicant intends to provide and request endorsement for each program ~~service~~type as described in OAR 411-323-0035.

(d) The applicant must demonstrate proof of liability and operational insurance coverage.

(A) The agency must, at the expense of the agency, maintain in effect with respect to all occurrences taking place during the certification period, liability and operational insurance as described in the contract the agency has with the Department including, but not limited to, automobile liability insurance,

comprehensive or commercial general liability insurance, and workers' compensation coverage if required.

(B) The agency must name the State of Oregon, Department of Human Services and the divisions, officers, and employees of the Department as additionally insured on any insurance policies required by their contract with respect to agency activities being performed under the certification of the agency. Such insurance must be issued by an insurance company licensed to do business in the state of Oregon and must contain a 30 day notice of cancellation endorsement.

(C) The agency must forward certificates of insurance indicating coverage to the Department as required by this rule.

(D) In the event of unilateral cancellation or restriction by the insurance company of any insurance coverage required by their contract, the agency must immediately notify the Department orally of the cancellation or restriction and must confirm the cancellation or restriction in writing within three days of receiving notification from the insurance company.

(4) CERTIFICATE RENEWAL.

(a) To renew a certificate, the agency must:

(A) Submit an application to the Department at least 90 days prior to the expiration date of the existing certificate for the agency. The completed application must be on a form provided by the Department and must include all information requested by the Department. At a minimum, the agency must provide:

(i) A copy of any management agreements or contracts relative to the operation and ownership of the agency;

(ii) A financial plan that includes audits for the last two years as described in section (5) of this rule; and

(iii) As required by 42 CFR 455.104, the name, date of birth, and social security number for each person

currently serving as the Board of Directors for the agency, and as changes are made.

(B) Identify the scope of ~~program~~ services the agency provides and provide proof of endorsement for each program service as described in OAR 411-323-0035;

(C) Demonstrate to the satisfaction of the Department that the agency is in compliance with these rules, the rules in OAR chapter 411, division 004, and the corresponding program rules; and

(D) Demonstrate proof of continued liability and operational insurance coverage as described in section (3)(d) of this rule.

(b) An application for renewal filed with the Department before the date of expiration extends the effective date of the existing certificate until the Department takes action upon the application for renewal.

(c) If the renewal application is not submitted to the Department prior to the date the certificate expires, the agency is considered a non-certified Medicaid agency and is subject to termination of their Medicaid Agency Identification Number.

(5) FINANCIAL AUDITS. Agencies certified and endorsed to provide program services, receiving revenue of $1,000,000 or more per fiscal year, must obtain an audit at least once during the biennium~~. On alternating years, the agency may obtain~~. Agencies certified and endorsed receiving less than $1,000,000 in revenue per fiscal year must submit to ODDS an audit review as defined in OAR 411-323-0020 or another financial audit. The audit or the audit review must be submitted to the Department within 90 days of the end of the fiscal year.

(6) CERTIFICATE EXPIRATION. Unless revoked, suspended, or terminated earlier, each certificate to operate as a Medicaid provider agency expires ~~five~~two years following the date of issuance or December 31, 2017 if issued prior to January 1, 2016.

(7) CERTIFICATE TERMINATION. The certificate automatically terminates on the date agency operation is discontinued or if there is a change in ownership.

(8) RETURN OF CERTIFICATE. The certificate must be returned to the Department immediately upon suspension or revocation of the certificate or when agency operation is discontinued.

(9) CHANGE OF OWNERSHIP, LEGAL ENTITY, LEGAL STATUS, OR MANAGEMENT CORPORATION.

(a) The agency must notify the Department in writing of any pending change in the ownership, legal entity, legal status, or management corporation of the agency.

(b) A new certificate is required upon a change in the ownership, legal entity, legal status, or management corporation of the agency. The agency must submit an application as described in section (3) of this rule to the Department at least 30 days prior to a change in ownership, legal entity, legal status, or management corporation.

(10) CERTIFICATE ADMINISTRATIVE SANCTION. An administrative sanction may be imposed for non-compliance with these rules, the rules in OAR chapter 411 division 004, or the corresponding program rules. An administrative sanction on a certificate includes one or more of the following actions:

(a) A condition as described in section (11) of this rule;

(b) Denial, revocation, or refusal to renew a certificate as described in section (12) of this rule; or

(c) Immediate suspension of a certificate as described in section (13) of this rule.

(11) CERTIFICATE CONDITIONS.

(a) The Department may attach conditions to a certificate that limit, restrict, or specify other criteria for operation of the agency. The type

of condition attached to a certificate must directly relate to the risk of harm or potential risk of harm to individuals.

(b) The Department may attach a condition to a certificate upon a finding that:

(A) Information on the application or initial inspection requires a condition to protect the health, safety, or welfare of individuals;

(B) A threat to the health, safety, or welfare of an individual exists;

(C) There is reliable evidence of abuse, neglect, or exploitation; or

(D) The agency is not being operated in compliance with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules.

(c) Conditions that the Department may impose on a certificate include, but are not limited to:

(A) Restricting the total number of individuals to whom an agency may provide services;

(B) Restricting the total number of individuals to whom an agency may provide ~~program~~ services based upon the capability and capacity of the agency and staff to meet the health and safety needs of all individuals;

(C) Restricting the type of support and services the agency may provide to individuals based upon the capability and capacity of the agency and staff to meet the health and safety needs of all individuals;

(D) Requiring additional staff or staff qualifications;

(E) Requiring additional training;

(F) Restricting the agency from allowing a person on the premises who may be a threat to the health, safety, or welfare of an individual;

(G) Requiring additional documentation; or

(H) Restricting admissions.

(d) NOTICE OF CERTIFICATE CONDITIONS. The Department issues a written notice to the agency when the Department imposes conditions on the certificate of the agency. The written notice of certificate conditions includes the conditions imposed by the Department, the reason for the conditions, and the opportunity to request a hearing under ORS chapter 183. Conditions take effect immediately upon issuance of the written notice of certificate conditions or at a later date as indicated on the notice and are a Final Order of the Department unless later rescinded through the hearing process. The conditions imposed remain in effect until the Department has sufficient cause to believe the situation that warranted the condition has been remedied.

(e) HEARING. The agency may request a hearing in accordance with ORS chapter 183 and this rule upon receipt of written notice of certificate conditions. The request for a hearing must be in writing.

(A) The agency must request a hearing within 21 days from the receipt of the written notice of certificate conditions.

(B) In addition to, or in-lieu of a hearing, an agency may request an administrative review as described in section (14) of this rule. The request for an administrative review must be in writing. The administrative review does not diminish the right of the agency to a hearing.

(f) The agency may send a written request to the Department to remove a condition if the agency believes the situation that warranted the condition has been remedied.

(g) Conditions must be posted with the certificate in a prominent location and be available for inspection at all times.

(12) CERTIFICATE DENIAL, REFUSAL TO RENEW, OR REVOCATION.

(a) The Department may deny, refuse to renew, or revoke a certificate when the Department finds the agency or any person holding 5 percent or greater ownership interest in the agency:

(A) Demonstrates substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized and the agency fails to correct the non-compliance within 30 days from the receipt of written notice of non-compliance;

(B) Has demonstrated a substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized;

(C) Has been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of program services;

(D) Has been convicted of a misdemeanor associated with the operation of an agency or program services;

(E) Falsifies information required by the Department to be maintained or submitted regarding program services, agency finances, or funds belonging to the individuals;

(F) Has been found to have permitted, aided, or abetted any illegal act that has had significant adverse impact on individual health, safety, or welfare; or

(G) Has been placed on the current Centers for Medicare and Medicaid Services list of excluded or debarred providers maintained by the Office of the Inspector General.

(b) NOTICE OF CERTIFICATE DENIAL, REVOCATION, OR REFUSAL TO RENEW. The Department may issue a notice of

denial, refusal to renew, or revocation of a certificate following a Department finding that there is a substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in subsection (a) of this section has occurred.

(c) HEARING. An applicant for a certificate or a certified agency, as applicable, may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential setting, upon written notice from the Department of denial, refusal to renew, or revocation of a certificate. The request for a hearing must be in writing.

(A) DENIAL. The applicant must request a hearing within 60 days from the receipt of the written notice of denial.

(B) REFUSAL TO RENEW. The agency must request a hearing within 60 days from the receipt of the written notice of refusal to renew.

(C) REVOCATION.

(i) Notwithstanding subsection (ii) of this section, the agency must request a hearing within 21 days from the receipt of the written notice of revocation.

(I) In addition to, or in-lieu of a hearing, the agency may request an administrative review as described in section (14) of this rule. The request for an administrative review must be in writing.

(II) The administrative review does not diminish the right of the agency to a hearing.

(ii) ~~24-HOUR RESIDENTIAL SETTINGS.~~ An agency endorsed to ~~provide services in~~operate a 24-hour residential ~~setting~~program as described in OAR chapter 411, division 325 must request a hearing within 10 days from the receipt of the written notice of revocation.

(13) IMMEDIATE SUSPENSION OF CERTIFICATE.

(a) When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the agency, immediately suspend a certificate without a pre-suspension hearing and the agency may not continue operating.

(b) HEARING. The agency may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential setting, upon written notice from the Department of the immediate suspension of the certificate. The request for a hearing must be in writing.

(A) Notwithstanding subsection (B) of this section, the agency must request a hearing within 21 days from the receipt of the written notice of suspension.

(i) In addition to, or in-lieu of a hearing, the agency may request an administrative review as described in section (14) of this rule. The request for an administrative review must be in writing.

(ii) The administrative review does not diminish the right of the agency to a hearing.

(B) ~~24-HOUR RESIDENTIAL SETTINGS.~~ An agency endorsed to ~~provide services in~~operate a 24-hour residential ~~setting~~program as described in OAR chapter 411, division 325 must request a hearing within 10 days from the receipt of the written notice of suspension.

(14) ADMINISTRATIVE REVIEW.

(a) Notwithstanding subsection (b) of this section, the agency, in addition to the right to a hearing, may request an administrative review. The request for an administrative review must be in writing.

(b) ~~24-HOUR RESIDENTIAL SETTINGS.~~ An agency endorsed to ~~provide services in~~operate a 24-hour residential ~~setting~~program as described in OAR chapter 411, division 325 may not request an administrative review for revocation or suspension. An agency endorsed to ~~provide services in~~operate a 24-hour residential ~~setting~~program as described in OAR chapter 411, division 325 may request an administrative review for imposition of conditions.

(c) The Department must receive a written request for an administrative review within 10 business days from the receipt of the notice of suspension, revocation, or imposition of conditions. The agency may submit, along with the written request for an administrative review, any additional written materials the agency wishes to have considered during the administrative review.

(d) The determination of the administrative review is issued in writing within 10 business days from the receipt of the written request for an administrative review, or by a later date as agreed to by the agency.

(e) The agency, notwithstanding subsection (b) of this section, may request a hearing if the decision of the Department is to affirm the suspension, revocation, or condition. The request for a hearing must be in writing. The Department must receive the written request for a hearing within 21 days from the receipt of the original written notice of suspension, revocation, or imposition of conditions.

(15) INFORMAL CONFERENCE. Unless an administrative review has been completed as described in section (14) of this rule, an applicant or agency requesting a hearing may have an informal conference with the Department.

Stat. Auth. ORS 409.050
Stats. Implemented: ORS 409.050

411-323-0035 Endorsement

(1) ENDORSEMENT REQUIRED. Except for an agency with a current certification, or that has applied for certification, according to OAR 411-340-0140 prior to January 1, 2016, a~~A~~ person, agency, or governmental unit acting individually or jointly with any other person, agency, or

governmental unit intending to ~~provide~~operate a program ~~services~~type as defined in OAR 411-323-0020 must be endorsed by the Department under these rules before establishing, conducting, maintaining, managing, or operating a ~~service setting~~program.

(a) Except as described in OAR 411-450-0070, ~~E~~endorsements are not transferable or applicable to any other ~~service setting~~ program type. Separate endorsements are required for each program ~~service provided~~type operated by a certified agency. A certified agency intending to ~~provide~~operate additional program ~~services~~types once initial endorsement has been issued must apply for an additional endorsement as described in section (3) of this rule.

(b) If required by the program rules, ~~E~~each geographic location where a program ~~services are provided~~operates must be reported by the agency to the Department and to the corresponding CDDP of the geographic location as described in this rule.

(c) The Department issues or renews an endorsement to a certified agency found to be in compliance with these rules, the rules in OAR chapter 411 division 004, and the corresponding program rules. The effective date for each endorsement corresponds with the effective date for the certification of the agency unless sooner revoked or suspended.

(d) If a certified agency fails to provide complete, accurate, and truthful information during the application or renewal process, the Department may delay initial endorsement, deny the application, or revoke or refuse to renew the endorsement ~~for~~of the program ~~services~~.

(e) For the purpose of endorsement, any applicant or person with an ownership interest in a certified agency is considered responsible for acts occurring during, and relating to, the operation of the agency.

(f) The Department may consider the background and operating history of the applicant and each person with an ownership interest when determining whether to issue or renew an endorsement.

(g) A review of the certified agency is conducted by the Department prior to the issuance or renewal of an endorsement.

(2) CURRENT AGENCY ENDORSEMENT.

(a) All certified agencies ~~providing~~endorsed to operate a program ~~services~~ as of ~~July~~January 1, ~~2011~~2016 are endorsed for ~~five~~not more than two years ~~for the program services being provided as of July 1, 2011 unless the endorsement is sooner revoked or suspended~~.

(b) A certified agency intending to ~~provide~~operate additional program ~~services after July 1, 2011~~types must apply for endorsement as described in section (3) of this rule.

(c) Agencies licensed or certified under OAR chapter 411, division 054 for residential care and assisted living facilities, OAR chapter 309, division 035 for residential care treatment facilities for individuals who are mentally or emotionally disturbed, OAR chapter 413, division 215 for child welfare private child caring agencies, or OAR chapter 416, division 550 for youth offender treatment foster care, and as may be described in corresponding program rules, do not require additional endorsement as an agency under these rules to ~~provide program~~ deliver services described in the program rules.

(3) INITIAL ENDORSEMENT.

(a) Notwithstanding section (2) of this rule, a certified agency intending to ~~provide~~operate a program ~~services~~ as defined in OAR 411-323-0020 must apply for initial endorsement and demonstrate to the satisfaction of the Department that the agency is in compliance with these rules, the rules in OAR chapter 411 division 004, and the corresponding program rules.

(b) The certified agency must submit an application to the Department at least 90 days prior to ~~providing program~~ delivering services that identifies the program ~~services~~type that the certified agency intends to ~~provide and~~operate.

(A) ~~a~~All geographic locations where ~~program services~~programs are to be ~~provided~~operated must be identified on the application, if required by the program rules.

(B~~A~~) The completed application must be on a form provided by the Department and must include all information requested by the Department.

(C~~B~~) Each licensed site or geographic location where direct services are to be delivered must be assigned a Medicaid Performing Provider Number by the Department as described in OAR chapter 411, division 370.

(4) ENDORSEMENT RENEWAL.

(a) To renew endorsement, the certified agency must:

(A) Submit an application to the Department at least 90 days prior to the expiration date of the existing endorsement for the certified agency. The completed application must identify the program ~~services~~type that the certified agency provides and all geographic locations where program services are provided, when required by the program rules. The completed application must be on a form provided by the Department and must include all information requested by the Department.

(B) Demonstrate to the satisfaction of the Department that the certified agency is in compliance with these rules, the rules in OAR chapter 411 division 004, and the corresponding program rules.

(b) Only existing program ~~services~~types are endorsed on renewal. A certified agency requesting to ~~provide~~operate additional program ~~services~~types must apply for initial endorsement as described in section (3) of this rule.

(c) An application for renewal filed with the Department before the date of expiration extends the effective date of the existing endorsement until the Department takes action upon the application for renewal.

(d) A certified agency may not ~~provide~~operate a program ~~services~~ if a renewal application is not submitted to the Department prior to the date the endorsement expires.

(e) Renewal of endorsements for a program ~~services~~ is contingent upon the successful renewal of the certificate of the agency.

(5) EXISTING ENDORSEMENT - ADDING A GEOGRAPHIC LOCATION. Adding a geographic location to an existing endorsement must be reported by the agency to the Department and to the corresponding CDDP of the geographic location. The agency must report the additional geographical location on a form provided by the Department at least 30 days prior to ~~providing program~~delivering services at the additional geographic location.

(6) ENDORSEMENT EXPIRATION. Unless revoked, suspended, or terminated earlier, the effective date of each endorsement corresponds with the effective date of the certification of the agency.

(7) ENDORSEMENT TERMINATION. Endorsement automatically terminates on the date ~~program services~~programs are discontinued or agency certification is terminated.

(8) CHANGE OF CERTIFICATION. New endorsement is required upon a change of the certification of an agency. The recertified agency must submit an application for endorsement as described in section (3) of this rule to the Department at least 30 days prior to a change of the certification of the agency including, but not limited to, a change in ownership, legal entity, legal status, or management corporation.

(9) ENDORSEMENT ADMINISTRATIVE SANCTION. An administrative sanction may be imposed for non-compliance with these rules, the corresponding program rules, or the rules in OAR chapter 411 division 004. An administrative sanction on an endorsement includes one or more of the following actions:

(a) A condition as described in section (10) of this rule:

(b) Denial, revocation, or refusal to renew an endorsement as described in section (11) of this rule; or

(c) Immediate suspension of an endorsement as described in section (12) of this rule.

(10) ENDORSEMENT CONDITIONS.

(a) The Department may attach conditions to an endorsement that limit, restrict, or specify other criteria for a program ~~services~~. The type of condition attached to an endorsement must directly relate to a risk of harm or potential risk of harm to individuals.

(b) The Department may attach a condition to an endorsement upon a finding that:

(A) Information on the application or initial inspection requires a condition to protect the health, safety, or welfare of individuals;

(B) A threat to the health, safety, or welfare of an individual exists;

(C) There is reliable evidence of abuse, neglect, or exploitation; or

(D) The agency is not being operated in compliance with these rules, the rules in OAR chapter 411 division 004, or the corresponding program rules.

(c) Conditions that the Department may impose on an endorsement include, but are not limited to:

(A) Restricting the total number of individuals to whom an agency may ~~provide~~deliver services;

(B) Restricting the total number of individuals to whom an agency may ~~provide program~~deliver services based upon the capability and capacity of the agency and staff to meet the health and safety needs of all individuals;

(C) Restricting the type of support and services the agency may ~~provide~~deliver to individuals based upon the capability and

capacity of the agency and staff to meet the health and safety needs of all individuals;

(D) Requiring additional staff or staff qualifications;

(E) Requiring additional training;

(F) Restricting the agency from allowing a person on the premises who may be a threat to the health, safety, or welfare of an individual;

(G) Requiring additional documentation; or

(H) Restricting admissions.

(d) NOTICE OF ENDORSEMENT CONDITIONS. The Department issues a written notice to the agency when the Department imposes conditions on the endorsement of a program ~~services.~~ The written notice of endorsement conditions includes the conditions imposed by the Department, the reason for the conditions, and the opportunity to request a hearing under ORS chapter 183. Conditions take effect immediately upon issuance of the written notice of conditions or at a later date as indicated on the notice and are a Final Order of the Department unless later rescinded through the hearing process. The conditions imposed remain in effect until the Department has sufficient cause to believe the situation that warranted the condition has been remedied.

(e) HEARING. The agency may request a hearing in accordance with ORS chapter 183 and this rule upon written notice of endorsement conditions. The request for a hearing must be in writing.

(A) The agency must request a hearing within 21 days from the receipt of the written notice of conditions.

(B) In addition to, or in lieu of a hearing, the agency may request an administrative review as described in section (13) of this rule. The request for an administrative review must be in writing. The administrative review does not diminish the right of the agency to a hearing.

(f) The agency may send a written request to the Department to remove a condition if the agency believes the situation that warranted the condition has been remedied.

(g) Conditions must be posted with the endorsement in a prominent location and be available for inspection at all times.

(11) ENDORSEMENT DENIAL, REFUSAL TO RENEW, OR REVOCATION.

(a) The Department may deny, refuse to renew, or revoke an endorsement when the Department finds the agency or any person holding 5 percent or greater ownership interest in the agency:

(A) Fails to maintain agency certification as described in OAR 411-323-0030;

(B) Demonstrates substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized and the agency fails to correct the non-compliance within 30 days from the receipt of the written notice of non-compliance;

(C) Has demonstrated a substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized;

(D) Has been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of services;

(E) Has been convicted of a misdemeanor associated with the operation of an agency or program services;

(F) Falsifies information required by the Department to be maintained or submitted regarding program services, agency finances, or funds belonging to the individuals;

(G) Has been found to have permitted, aided, or abetted any illegal act that has had significant adverse impact on individual health, safety, or welfare; or

(H) Has been placed on the list of excluded or debarred providers maintained by the Office of the Inspector General.

(b) NOTICE OF ENDORSEMENT DENIAL, REFUSAL TO RENEW, OR REVOCATION. The Department may issue a notice of denial, refusal to renew, or revocation of an endorsement following a Department finding that there is a substantial failure to comply with these rules, the rules in OAR chapter 411, division 004, or the corresponding program rules such that the health, safety, or welfare of individuals is jeopardized, or that one or more of the events listed in subsection (a) of this section has occurred.

(c) HEARING. An applicant for an endorsement or an endorsed agency, as applicable, may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential setting, upon written notice from the Department of denial, refusal to renew, or revocation of an endorsement. The request for a hearing must be in writing.

(A) DENIAL. The applicant must request a hearing within 60 days from the receipt of the written notice of denial.

(B) REFUSAL TO RENEW. The agency must request a hearing within 60 days from the receipt of the written notice of refusal to renew.

(C) REVOCATION.

(i) Notwithstanding subsection (ii) of this section, the agency must request a hearing within 21 days from the receipt of the written notice of revocation.

(I) In addition to, or in lieu of a hearing, an agency may request an administrative review as described

in section (13) of this rule. The request for an administrative review must be in writing.

(II) The administrative review does not diminish the right of the agency to a hearing.

(ii) ~~24-HOUR RESIDENTIAL SETTINGS.~~ An agency endorsed to ~~provide services in~~operate a 24-hour residential ~~setting~~program as described in OAR chapter 411, division 325 must request a hearing within 10 days from the receipt of the written notice of revocation.

(12) IMMEDIATE SUSPENSION OF ENDORSEMENT.

(a) When the Department finds a serious and immediate threat to individual health and safety and sets forth the specific reasons for such findings, the Department may, by written notice to the agency, immediately suspend an endorsement without a pre-suspension hearing and the program ~~service~~ may not continue operating.

(b) HEARING. The agency may request a hearing in accordance with ORS chapter 183, this rule, and ORS 443.440 for a 24-hour residential ~~setting~~program, upon written notice from the Department of the immediate suspension of the endorsement. The request for a hearing must be in writing.

(A) Notwithstanding subsection (B) of this section, the endorsed agency must request a hearing within 21 days from the receipt of the written notice of suspension.

(i) In addition to, or in-lieu of a hearing, the agency may request an administrative review as described in section (13) of this rule. The request for an administrative review must be in writing.

(ii) The administrative review does not diminish the right of the agency to a hearing.

(B) ~~24-HOUR RESIDENTIAL SETTINGS.~~ An agency endorsed to ~~provide services in~~operate a 24-hour residential

~~setting~~program as described in OAR chapter 411, division 325 must request a hearing within 10 days from the receipt of the written notice of suspension.

(13) ADMINISTRATIVE REVIEW.

(a) Notwithstanding subsection (b) of this section, the agency, in addition to the right to a hearing, may request an administrative review. The request for an administrative review must be in writing.

(b) ~~24-HOUR RESIDENTIAL SETTINGS.~~ An agency endorsed to ~~provide services in~~operate a 24-hour residential ~~setting~~program as described in OAR chapter 411, division 325 may not request an administrative review for revocation or suspension. An agency endorsed to ~~provide services in~~operate a 24-hour residential ~~setting~~program as described in OAR chapter 411, division 325 may request an administrative review for imposition of conditions.

(c) The Department must receive a written request for an administrative review within 10 business days from the receipt of the notice of suspension, revocation, or imposition of conditions. The agency may submit, along with the written request for an administrative review, any additional written materials the agency wishes to have considered during the administrative review.

(d) The determination of the administrative review is issued in writing within 10 business days from the receipt of the written request for an administrative review, or by a later date as agreed to by the agency.

(e) The agency, notwithstanding subsection (b) of this section, may request a hearing if the decision of the Department is to affirm the suspension, revocation, or condition. The request for a hearing must be in writing. The Department must receive the written request for a hearing within 21 days from the receipt of the original written notice of suspension, revocation, or imposition of conditions.

(14) INFORMAL CONFERENCE. Unless an administrative review has been completed as described in subsection (13) of this rule, an applicant or agency requesting a hearing may have an informal conference with the Department.

Stat. Auth. ORS 409.050
Stats. Implemented: ORS 409.050

411-323-0050 Agency Management and Personnel Practices

(1) NON-DISCRIMINATION. The agency must comply with all applicable state and federal statutes, rules, and regulations in regard to non-discrimination in employment policies and practices.

(2) BASIC PERSONNEL POLICIES AND PROCEDURES. The agency must have in place and implement personnel policies and procedures that address suspension, increased supervision, or other appropriate disciplinary employment procedures when a staff member, provider, or subcontractor, including relief providers and volunteers, has been identified as an accused person in an abuse investigation or when an allegation of abuse has been substantiated.

(3) PROHIBITION AGAINST RETALIATION. The agency or provider may not retaliate against any staff member or subcontractor including relief providers and volunteers that report in good faith suspected abuse or retaliate against the individual with respect to any report. An accused person may not self-report solely for the purpose of claiming retaliation.

(a) Any agency, provider, or person that retaliates against any person because of a report of suspected abuse or neglect is liable according to ORS 430.755 in a private action to the reporting person for actual damages and, in addition, is subject to a penalty up to $1000, notwithstanding any other remedy provided by law.

(b) Any adverse action is evidence of retaliation if taken within 90 days of a report of abuse. For purposes of this section, "adverse action" means any action taken by an agency, provider, or person involved in a report against the person making the report or against the individual because of the report and includes, but is not limited to:

(A) Discharge or transfer from the agency, except for clinical reasons;

(B) Discharge from or termination of employment;

(C) Demotion or reduction in remuneration for program services; or

(D) Restriction or prohibition of access to the agency or the individuals receiving services by the agency.

(4) MANDATORY ABUSE REPORTING PERSONNEL POLICIES AND PROCEDURES.

(a) Any staff, providers, substitute caregivers, independent contractors of the agency, and volunteers are mandatory reporters.

(b) The agency must notify all staff, providers, substitute caregivers, independent contractors of the agency, and volunteers of mandatory reporting status at least annually on forms provided by the Department.

(c) The agency must provide all staff, providers, substitute caregivers, independent contractors of the agency, and volunteers with a Department produced card regarding abuse reporting status and abuse reporting requirements.

(d) Agencies providing services to adults must report suspected abuse to the CDDP where the adult resides. A report must also be made to law enforcement if there is reason to believe a crime has been committed.

(e) Agencies providing services to children must report suspected abuse to the Department or law enforcement in the county where the child resides.

(5) APPLICATION FOR EMPLOYMENT. An application for employment at the agency must inquire whether an applicant has had any founded reports of child abuse or substantiated adult abuse.

(6) BACKGROUND CHECKS. Any staff, volunteer, provider, relief care provider, crisis provider, advisor, or any subject individual defined by OAR 407-007-0210, including staff who are not identified in this rule but use public funds intended for the operation of an agency, who has or shall have

contact with an individual in services, must have an approved background check in accordance with OAR 407-007-0200 to 407-007-0370 and ORS 181.534.

(a) ~~Effective July 28, 2009, t~~The agency may not use public funds to support, in whole or in part, any person described above in section (6) of this rule in any capacity who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(b) Subsection (a) of this section does not apply to agency staff who were hired prior to July 28, 2009 that remain in the current position for which the staff member was hired.

(c) Any person described above in section (6) of this rule must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and OAR 407-007-0290. The person must notify the Department or the designee of the Department within 24 hours.

(7) EXECUTIVE DIRECTOR QUALIFICATIONS. The agency must be operated under the supervision of an Executive Director who has a minimum of a bachelor's degree and two years of experience, including supervision, in intellectual or developmental disabilities, mental health, rehabilitation, social services, or a related field. Six years of experience in the identified fields may be substituted for a degree.

(8) GENERAL STAFF QUALIFICATIONS. Any staff member providing services to individuals must meet the following criteria:

(a) Be at least 18 years of age;

(b) Consent to and pass a background check by the Department as described in OAR 407-007-0200 to 407-007-0370 and section (6) of this rule, and be free of convictions or founded allegations of abuse by the appropriate agency including, but not limited to, the Department;

(A) Background rechecks must be performed ~~biannually~~biennially, or as needed, if a report of criminal activity has been received by the Department.

(B) PORTABILITY OF BACKGROUND CHECK APPROVAL. A subject individual as defined in OAR 407-007-0210 may be approved for one position to work in multiple locations within the qualified entity as defined in OAR 407-007-0210. The Background Check Request form must be completed by the subject individual to show intent to work at various locations.

(c) If hired on or after July 28, 2009, not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275:

(d) Be legally eligible to work in the United States;

(e) Hold a current, valid, and unrestricted professional license or certification where services and supervision requires specific professional education, training, and skill;

(f) Understand requirements of maintaining confidentiality and safeguarding individual information;

(g) Not be on the list of excluded or debarred providers maintained by the Office of the Inspector General;

(h) Be literate and capable of understanding written and oral orders;

(i) Be able to communicate with individuals, health care providers, ~~service coordinators~~case managers, and appropriate others;

(j) Be able to respond to emergency situations at all times that services are being delivered;

(k) Be certified in CPR and First Aid by a recognized training agency within 90 days of employment;

(l) Receive 12 hours of job-related in-service training annually;

(m) Have clear job responsibilities as described in a current signed and dated job description; and

(n) If transporting individuals, have a valid license to drive and vehicle insurance in compliance with the laws of the Department of Motor Vehicles.

(o) Additional qualifications may exist in the applicable program rules for the staff of an agency endorsed to those rules.

(9) PERSONNEL FILES AND QUALIFICATION RECORDS. The agency must maintain up-to-date written job descriptions for all staff as well as a file available to the Department or the designee of the Department for inspection that includes written documentation of the following for each staff member:

(a) Written documentation that references and qualifications were checked;

(b) Written documentation by the Department of an approved background check as defined in OAR 407-007-0210;

(c) Written documentation of staff notification of mandatory abuse training and reporter status prior to supervising individuals and annually thereafter;

(d) Written documentation of any complaints filed against the staff member and the results of the complaint process, including, if any, disciplinary action;

(e) Written documentation of any founded report of child abuse or substantiated adult abuse;

(f) Written documentation of 12 hours of job-related in-service training annually;

(g) Documentation that the staff member has been certified in CPR and First Aid by a recognized training agency within 90 days of employment and that certification is kept current; and

(h) For staff operating vehicles that transport individuals, documentation of a valid license to drive and proof of vehicle

insurance in compliance with the laws of the Department of Motor Vehicles.

(10) DISSOLUTION OF AN AGENCY. A representative of the governing body or owner of an agency must notify the Department in writing 30 days prior to the dissolution of the agency and make appropriate arrangements for the transfer of individual records.

Stat. Auth. ORS 409.050
Stats. Implemented: ORS 409.050

411-323-0060 Policies and Procedures

~~(1) INDIVIDUAL RIGHTS.~~

~~(a) The agency must have and implement written policies and procedures that protect the rights of individuals described in subsection (d) of this section and encourage and assist individuals to understand and exercise these rights.~~

~~(b) Upon entry and request and annually thereafter, the individual rights described in subsection (d) of this section must be provided to an individual and the legal or designated representative of the individual.~~

~~(c) The individual rights described in this rule apply to all individuals eligible for or receiving developmental disability services. A parent or guardian may place reasonable limitations on the rights of a child.~~

~~(d) While receiving developmental disability services, an individual has the right to:~~

~~(A) Be free and protected from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;~~

~~(B) Be free from seclusion, unauthorized training or treatment, protective physical intervention, chemical restraint, or mechanical restraint and assured that medication is administered only for the clinical needs of the individual as~~

~~prescribed by a health care provider unless an imminent risk of physical harm to the individual or others exists and only for as long as the imminent risk continues;~~

~~(C) Individual choice for an adult to consent to or refuse treatment unless incapable and then an alternative decision maker must be allowed to consent to or refuse treatment for the adult. For a child, the parent or guardian of the child must be allowed to consent to or refuse treatment, except as described in ORS 109.610 or limited by court order;~~

~~(D) Informed, voluntary, written consent prior to receiving services, except in a medical emergency or as otherwise permitted by law;~~

~~(E) Informed, voluntary, written consent prior to participating in any experimental programs;~~

~~(F) A humane service environment that affords reasonable protection from harm, reasonable privacy in all matters that do not constitute a documented health and safety risk to the individual, and access and the ability to engage in private communications with any public or private rights protection program, services coordinator, personal agent, and others chosen by the individual through personal visits, mail, telephone, or electronic means;~~

~~(G) Contact and visits with legal and medical professionals, legal and designated representatives, family members, friends, advocates, and others chosen by the individual, except where prohibited by court order;~~

~~(H) Participate regularly in the community and use community resources, including recreation, developmental disability services, employment services, school, educational opportunities, and health care resources;~~

~~(I) For individuals less than 21 years of age, access to a free and appropriate public education, including a procedure for school attendance or refusal to attend;~~

~~(J) Reasonable and lawful compensation for performance of labor, except personal housekeeping duties;~~

~~(K) Manage his or her own money and financial affairs unless the right has been taken away by court order or other legal procedure;~~

~~(L) Keep and use personal property, personal control and freedom regarding personal property, and a reasonable amount of personal storage space;~~

~~(M) Adequate food, housing, clothing, medical and health care, supportive services, and training;~~

~~(N) Seek a meaningful life by choosing from available services, service settings, and providers consistent with the support needs of the individual identified through a functional needs assessment and enjoying the benefits of community involvement and community integration:~~

> ~~(i) Services must promote independence and dignity and reflect the age and preferences of the individual; and~~
>
> ~~(ii) The services must be provided in a setting and under conditions that are most cost effective and least restrictive to the liberty of the individual, least intrusive to the individual, and that provide for self-directed decision-making and control of personal affairs appropriate to the preferences, age, and identified support needs of the individual;~~

~~(O) An individualized written plan for services created through a person-centered planning process, services based upon the plan, and periodic review and reassessment of service needs;~~

~~(P) Ongoing opportunity to participate in the planning of services in a manner appropriate to the capabilities of the individual, including the right to participate in the development and periodic revision of the plan for services, the right to be~~

~~provided with a reasonable explanation of all service considerations through choice advising, and the right to invite others chosen by the individual to participate in the plan for services;~~

~~(Q) Request a change in the plan for services and a reassessment of service needs;~~

~~(R) A timely decision upon request for a change in the plan for services;~~

~~(S) Advance written notice of any action that terminates, suspends, reduces, or denies a service or request for service and notification of other available sources for necessary continued services;~~

~~(T) A hearing to challenge an action that terminates, suspends, reduces, or denies a service or request for service;~~

~~(U) Exercise all rights set forth in ORS 426.385 and 427.031 if the individual is committed to the Department;~~

~~(V) Be informed at the start of services and annually thereafter of the rights guaranteed by this rule, the contact information for the protection and advocacy system described in ORS 192.517(1), the procedures for reporting abuse, and the procedures for filing complaints, reviews, or requests for hearings if services have been or are proposed to be terminated, suspended, reduced, or denied;~~

~~(W) Have these rights and procedures prominently posted in a location readily accessible to individuals and made available to representatives of the individual;~~

~~(X) Be encouraged and assisted in exercising all legal, civil, and human rights accorded to other citizens of the same age, except when limited by a court order;~~

~~(Y) Be informed of and have the opportunity to assert complaints as described in OAR 411-318-0015 with respect to~~

~~infringement of the rights described in this rule, including the right to have such complaints considered in a fair, timely, and impartial complaint procedure without any form of retaliation or punishment; and~~

~~(Z) Freedom to exercise all rights described in this rule without any form of reprisal or punishment.~~

~~(e) The rights described in this rule are in addition to, and do not limit, all other statutory and constitutional rights that are afforded all citizens including, but not limited to, the right to exercise religious freedom, vote, marry, have or not have children, own and dispose of property, and enter into contracts and execute documents unless specifically prohibited by law.~~

~~(f) An individual who is receiving developmental disability services has the right under ORS 430.212 and OAR 411-320-0090 to be informed that a family member has contacted the Department to determine the location of the individual and to be informed of the name and contact information of the family member, if known.~~

~~(g) The rights described in this rule may be asserted and exercised by an individual, the legal representative of an individual, and any representative designated by an individual.~~

~~(h) Nothing in this rule may be construed to alter any legal rights and responsibilities between a parent and child.~~

~~(i) A guardian is appointed for an adult only as is necessary to promote and protect the well-being of the adult. A guardianship for an adult must be designed to encourage the development of maximum self-reliance and independence of the adult, and may be ordered only to the extent necessitated by the actual mental and physical limitations of the adult. An adult for whom a guardian has been appointed is not presumed to be incompetent. An adult with a guardian retains all legal and civil rights provided by law, except those that have been expressly limited by court order or specifically granted to the guardian by the court. Rights retained by an adult include, but are not limited to, the right to contact and retain counsel and to have access to personal records. (ORS 125.300).~~

(~~2~~1) HEALTH. The agency must have and implement policies and procedures that maintain and protect the health of individuals.

(~~3~~2) INDIVIDUAL AND FAMILY INVOLVEMENT. The agency must have and implement a written policy that addresses:

(a) Opportunities for the individual to participate in decisions regarding the operations of the agency;

(b) Opportunities for families, guardians, legal and designated representatives, and significant others of the individuals to interact; and

(c) Opportunities for individuals, families, guardians, legal and designated representatives, and significant others to participate on the Board of Directors or on committees or to review policies of the agency that directly affect the individuals receiving services from the agency.

~~(4) INDEPENDENCE, PRODUCTIVITY, AND INTEGRATION. As stated in ORS 427.007, the agency must have a written policy that states each ISP for an individual is developed to meet the level of independence, productivity, and integration of the individual into the local community.~~

(~~5~~3) CONFIDENTIALITY OF RECORDS. The agency must have and implement written policies and procedures that ensure all records for individuals are kept confidential except as otherwise provided by applicable state and federal rule or laws.

(a) For the purpose of disclosure from individual medical records under this rule, an agency is considered a "public provider" as defined in ORS 179.505.

(b) Access to records by the Department does not require authorization by an individual or the legal or designated representative or family of the individual.

(c) For the purpose of disclosure of non-medical individual records, all or portions of the information contained in the non-medical individual

records may be exempt from public inspection under the personal privacy information exemption to the public records law set forth in ORS 192.502.

(~~6~~4) BEHAVIOR SUPPORT. The agency must have and implement a written policy for behavior support that utilizes individualized positive behavioral theory and practice and prohibits abusive practices.

(~~7~~5) PROTECTIVE PHYSICAL INTERVENTION. The agency must have and implement written policies and procedures for protective physical interventions that address the following:

(a) The agency must only employ protective physical intervention techniques that are included in the approved OIS curriculum or as approved by the OIS Steering Committee.

(b) Protective physical intervention techniques must only be applied:

(A) When the health and safety of an individual or others is at risk, the ISP team has authorized the procedures as documented by the decision of the ISP team, the procedures are documented in the ISP, and the procedures are intended to lead to less restrictive intervention strategies; or

(B) As an emergency measure if absolutely necessary to protect the individual or others from immediate injury; or

(C) As a health-related protection prescribed by a physician, if absolutely necessary during the conduct of a specific medical or surgical procedure, or for the protection of an individual during the time that a medical condition exists.

(~~8~~6) HANDLING AND MANAGING INDIVIDUALS' MONEY. The agency must have and implement written policies and procedures for the handling and management of money for the individuals. Such policies and procedures must provide for:

(a) Financial planning and management of the funds for an individual ~~unless the ISP documents and justifies limitations to self-management~~;

(b) Safeguarding the funds for an individual;

(c) Individuals receiving and spending their own money; and

(d) Taking into account the interests and preferences of the individual.

(~~9~~7) COMPLAINTS.

(a) Complaints by or on behalf of individuals must be addressed in accordance with OAR 411-318-0015.

(b) The agency must have and implement written policies and procedures for individual complaints in accordance with OAR 411-318-0015.

(c) Upon entry and request and annually thereafter, the policy and procedures for complaints must be explained and provided to an individual and the legal or designated representative of the individual (as applicable).

(~~10~~8) AGENCY DOCUMENTATION REQUIREMENTS. The agency must have and implement policies and procedures that address agency documentation requirements. Documentation must:

(a) Be prepared at the time or immediately following the event being recorded;

(b) Be accurate and contain no willful falsifications;

(c) Be legible, dated, and signed by the person making the entry; and

(d) Be maintained for no less than three years.

Stat. Auth. ORS 409.050
Stats. Implemented: ORS 409.050

411-323-0065 Payment to Agency Providers

(1) Authorization for payment in the appropriate electronic payment system must occur prior to the delivery of services

(2) Payment is made after services are delivered.

(3) For a service to be eligible for payment it must be included on a written agreement that specifies, at a minimum, the type and amount of services to be delivered. The written agreement must be signed by the provider and may be:

(a) The individual ISP, or

(b) A service agreement specific to the individual.

(4) A provider must request payment authorization from the case management entity for services provided during an unforeseeable emergency on the first business day following the emergency service. A case manager must determine if the service is eligible for payment.

(5) Travel time of the provider to reach the setting where services are delivered, when not directly providing services to the individual, is not reimbursable.

(6) Payment by the Department for a service is considered full payment for the services rendered under Medicaid. A provider may not demand or receive additional payment for services rendered under Medicaid from the individual, parent, guardian, or any other source, under any circumstances.

(7) Medicaid funds are the payer of last resort. A provider must bill all third party resources until all third party resources are exhausted.

(8) The Department reserves the right to make a claim against any third party payer before or after making payment to the provider.

(9) Upon submission of a request for payment, a provider must comply with:

(a) All applicable rules in OAR chapter 407 and OAR chapter 411;

(b) 45 CFR Part 84 which implements Title V, Section 504 of the Rehabilitation Act of 1973 as amended;

(c) Title II and Title III of the Americans with Disabilities Act of 1991; and

(d) Title VI of the Civil Rights Act of 1964.

(10) All billings must be for services provided within the licensure and certification of the provider.

(11) The provider must submit true and accurate information with request for payment.

(12) An agency may not submit the following to the Department:

(a) A false request for payment;

(b) A request for payment that has been, or is expected to be, paid by another source; or

(c) Any request for payment for services that have not been provided.

(13) The Department only makes payment to an enrolled provider who actually performs the services or the enrolled provider organization. Federal regulations prohibit the Department from making payment to a collection agency.

(14) Payment is denied if any provisions of these rules, the rules in OAR chapter 411, division 004, or the associated program rules are not complied with.

(15) The Department may recoup overpayments as described in OAR 407-120.

(16) In order to be eligible for payment, requests for payments must be submitted to the Department within 12 months of the delivery of services.

Stat. Auth.: ORS 409.050
Stats. Implemented: ORS 427.005, 427.007, 430.215

411-323-0070 Variances

(1) The Department may grant a variance to these rules or the corresponding program rules based upon a demonstration by an agency that an alternative method or different approach provides equal or greater agency effectiveness and does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws.

(2) The agency requesting a variance must submit a written application to the Department that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance;

(c) The alternative practice, service, method, concept, or procedure proposed; and

(d) If the variance applies to the services for an individual, evidence that the variance is consistent with the currently authorized ISP for the individual.

(3) The request for a variance is approved or denied by the Department. The decision of the Department is sent to the agency, the CDDP, and to all relevant Department programs or offices within 30 days from the receipt of the variance request.

(4) The agency may request an administrative review of the denial of a variance request. The Department must receive a written request for an administrative review within 10 business days from the receipt of the denial. The decision of the Director is the final response from the Department.

(5) The duration of the variance is determined by the Department.

(6) The agency may implement a variance only after written approval from the Department.

Stat. Auth. ORS 409.050
Stats. Implemented: ORS 409.050

DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 370

COMMUNITY SERVICES PROGRAMS

Provider Enrollment, Service Billing, and Service Payment

411-370-0010 Definitions

(1) "Administrator" means the administrators of the Department of Human Services or that person's designee.

(2) "Appropriate Service" means services that are required by a recipient's approved individual service or support plan that are:

(a) Consistent with the recipient's identified needs, goals, and desired outcomes;

(b) Appropriate with regard to standards of generally recognized practice, evidence based practice, and professional standards of service as effective;

(c) Not solely for the convenience of a provider of the service;

(d) The most cost effective of the alternative services that may be effectively provided to a recipient; and

(e) Coordinated with the recipient's local ~~community developmental disability program~~case management entity.

(3) "Authorization" means either service or payment authorization for specified covered services given prior to services being rendered by Department staff, or the Department's designee including community developmental disability programs and support services brokerages.

~~(4) "Benefit Package" means the array and type of services, as described by program-specific rules, for which the recipient is eligible.~~

(~~4~~5) "Billing Provider" means an individual, agent, business, corporation, or other entity who, in connection with submission of claims to the Department, receives or directs payment from the Department on behalf of a performing provider and has been delegated the authority to obligate or act on behalf of the performing provider.

(~~5~~6) "Claim" means a bill for services, a line item of a service, or all services for one recipient within a specified billing period. Claims include a bill submission, an invoice, or an encounter associated with requesting payment whether submitted on paper or electronically. Claim also includes any other methodology for requesting payment or as verification of an expenditure of an advanced payment that may be established in contract, provider enrollment agreement, or program-specific rules.

(~~6~~7) "~~Client Process Monitoring~~Express Payment and Reporting System (~~CPMS~~eXPRS)" means the Department's information system that tracks and documents service delivery of claims funded by the Department.

(~~7~~8) "Community Developmental Disability Program (CDDP)" as defined in OAR 411-320-0020.

(~~8~~9) "Community Services Programs" are developmental disability services provided for recipients under the following program names, service element numbers, or descriptions:

(a) Nursing facility specialized services (DD45) as described in OAR chapter 411, division 070.

(b) Residential ~~facilities~~programs (DD50) as described in OAR chapter 411, division 325.

(c) Supported living ~~services~~programs (DD51) as described in OAR chapter 411, division 328.

(d) Transportation services (DD 53) as described in the applicable service element standards and procedures~~.~~ and Community Transportation services described in OAR 411-435

(e) Employment ~~and community inclusion services (DD54)~~programs as described in OAR chapter 411, division 345.

(f) Community Living Supports as described in OAR chapter 411, division 450.

(g~~f~~) Rent subsidies (DD 56) as described in the applicable service element standards and procedures.

(h~~g~~) Developmental disabilities special projects (DD 57) as described in the applicable service element standards and procedures.

(i~~h~~) Children's residential ~~facilities~~programs (DD142) as described in OAR chapter 411, division 325.

~~(i) Children's proctor foster homes (DD143) as described in OAR chapter 411, division 335.~~

(j) Room and board (DD 156) as described in the applicable service element standards and procedures.

(1~~0~~9) "Covered Services" mean appropriate services that are funded by the legislature and applicable Department rules describing the ~~benefit packages of~~ community services programs provided to eligible recipients under service element standards and procedures, program-specific requirements, provider enrollment agreements, or contracts by providers required to enroll with the Department under these rules.

(10~~1~~) "Date of Service" means the date the recipient receives community services program services, unless otherwise specified in the appropriate program-specific rules.

(11~~2~~) "Department" means the Department of Human Services. For the purpose of these rules, Department also includes the responsibility for the day-to-day operation and administration of 1915(c) Home and Community-Based Services waiver and the 1915(k) Community First Choice State Plan Option programs of DHS as ~~its role~~ as ~~a delegated designee~~the operating agency designated by OHA. ~~of the Oregon Health Authority (OHA) in~~

~~carrying out the OHA responsibilities as the designated single Medicaid state agency~~.

(12~~3~~) "Express Payment and Reporting System (eXPRS)" means the Department's information system for managing the disbursement and tracking of Department funding for certain developmental disability programs.

(13~~4~~) "False Claim" means a claim or encounter that a provider knowingly submits or causes to be submitted that contains inaccurate or misleading information, and that information would result, or has resulted, in an overpayment or other improper payment.

(14~~5~~) "Fraud" means an intentional deception or misrepresentation made by a recipient or provider with the knowledge that the deception may result in some unauthorized benefit to himself or herself, or some other recipient or provider. Fraud includes any act that constitutes fraud or false claim under applicable federal or state law.

(15~~6~~) "Medicaid" means a federal and state funded program established by Title XIX of the Social Security Act, as amended, and administered in Oregon by the Department.

(16~~7~~) "Medicaid Agency Identification Number" means the numeric identifier assigned by the Department to an enrolled provider once enrollment of that provider is completed as described in these rules.

(17~~8~~) "Medicaid Performing Provider Number" means the numeric identifier assigned to an entity or person by the Department, following enrollment to deliver Medicaid funded services as described in these rules. The Medicaid Performing Provider Number is used by the rendering provider for identification and billing purposes associated with service authorizations and payments.

(18~~9~~) "Medicaid Fraud Control Unit (MFCU)" means the unit of the Oregon Department of Justice that investigates and prosecutes billing fraud committed by Medicaid providers. MFCU also may investigate and prosecute physical, sexual, or financial abuse and neglect of residents who reside in Medicaid-funded facilities.

(~~20~~19) "Medicaid Management Information System (MMIS)" means the automated claims processing and information retrieval system for handling all Medicaid transactions. The objectives of MMIS include verifying provider enrollment and client eligibility, managing health care provider claims and benefit package maintenance, and addressing a variety of Medicaid business needs.

(2~~0~~1) "Medicare" means the federal health insurance program for the aged and disabled administered by the Centers for Medicare and Medicaid Services under Title XVIII of the Social Security Act.

(21) "OHA" means Oregon Health Authority. OHA is the Single State Medicaid Agency for Oregon and retains ultimate authority and responsibility for the administration of the Medicaid State Plan.

(22) "Provider" or "Performing Provider" means an individual, agency, corporate entity, or other organization that provides community services program services that is enrolled with the Department in accordance with these rules to seek payment from the Department.

(23) "Quality Improvement" means the effort to improve the level of performance of key processes, practices, or outcomes in service provision. A quality improvement program measures the level of current performance of the processes and practices, finds ways to improve the performance or outcomes, and implements new and better methods for the processes or practices. Quality improvement includes the goals of quality assurance, quality control, quality planning, and quality management.

(24) "Recipient" means an individual found eligible by the community developmental disability program and the Department to receive community services program services for individuals with developmental disabilities under OAR chapter 411, division 320.

(25) "Service Element Standards and Procedures" means the standard for a particular service element number that further describes the applicable service and details the purpose, performance requirements, special reporting requirements, and applicable rules to adhere to when providing that particular service element.

(26) "SFMA" means the Oregon Statewide Financial Management Services.

(27) "Suspension" means a sanction prohibiting a provider's participation in the Department's community services programs by deactivation of the assigned provider number for a specified period of time or until the occurrence of a specified event.

(28) "These Rules" mean the rules in OAR chapter 411, division 370.

(29) "Third Party Resource (TPR)" means a service or financial resource that, by law, is available and applicable to pay for covered services for community services programs.

(30) "United States Department of Health & Human Services (USDHHS)" means the Cabinet department of the United States government with the goal of protecting the health of all Americans and providing essential human services.

Stat. Auth.: ORS 409.050, 410.070, 411.060, ~~&~~ 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610~~-to~~ 430.695, ~~&~~ 443.400~~-to~~ 443.455

411-370-0020 Provider Requirements

(1) These rules cover all programs and services of the Department's community services programs for recipients with developmental disabilities (hereinafter referred to as community services programs). All providers seeking payment from the Department for the provision of covered services to eligible service recipients of community services programs must comply with these rules and the applicable rules, standards, and procedures of the specific programs or services defined as community services programs in OAR 411-370-0010.

(2) COVERED PROVIDER AGREEMENTS. Agreements with providers for community services programs may include:

(a) Direct contracts with the Department;

(b) Contracts with Department designees, including CDDPs; or

(c) Provider enrollment agreements with the Department.

(3) Covered services paid for with state, Medicaid (Title XIX), or other funds by the Department for community services programs are also subject to federal and state Medicaid rules and requirements. In interpreting these rules and program-specific rules, the Department shall construe them as much as possible in a manner that shall comply with federal and state laws and regulations, and the terms and conditions of federal waivers and the state plans.

(4) A provider paid with state or Medicaid funds for community services programs must comply with all applicable federal and state laws and regulations pertaining to the provision of Medicaid services under the Medicaid Act, Title XIX, 42 United States Code (USC)1396 et seq.

(5) Payment for any service by a provider of community services programs may not be made by or through (directly or by power of attorney) any individual or organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the person or organization for an added fee or a deduction of a portion of the accounts receivable.

(6) The Department shall make community services programs provider payments to only the following:

(a) The provider who actually performed the service;

(b) In accordance with a reassignment from the provider to a government agency or reassignment by a court order; or

~~(c) An organization operating as an organized health care delivery system, if the provider has a contract under which the organization submits the claim and the organization is enrolled with the Department as a billing provider; or~~

(cd) To an enrolled billing provider, such as a billing service or an accounting firm that, in connection with the submission of claims, receives or directs payments in the name of the provider, if the billing provider's compensation for this service is:

(A) Related to the cost of processing the billing; and

(B) Not related on percentage or other basis to the amount that is billed or collected and not dependent upon the collection of the payment.

(7) Providers must comply with TPR requirements in Department policies, program-specific rules, provider enrollment agreements, or contracts.

(8) PROGRAM INTEGRITY.

(a) The Department shall use several approaches to promote integrity of the community services programs. This section of the rule describes integrity actions related to:

(A) Provider billings and payments, including actions and expectations contained within service element standards and procedures, program-specific rules, or contracts with Department representatives including CDDPs or brokerages. The program integrity goal is to pay the correct amount to a properly enrolled provider for covered services provided to an eligible recipient according to these rules and the program-specific services in effect on the date of the service; and

(B) Provider performance in the delivery of services to recipients as well as general program practices. The program integrity goal includes approaches to assure the provision of appropriate services for which payment is to be made as well as compliance with these rules, service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts.

(b) Program integrity activities include but are not limited to the following:

(A) Review, including but not limited to the evaluation of services in accordance with appropriate service or process, error identification, and prior authorization processes including all actions taken to determine the provision of services in

accordance with service element standards and procedures, program-specific rules, provider enrollment agreements, or contract;

(B) Onsite visits to verify compliance with service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts;

(C) Quality improvement activities;

(D) Coordination with the Department of Justice MFCU and other oversight authorities including law enforcement; and

(E) For provider billings and payments:

(i) Implementation of transaction standards to improve accuracy and timeliness of claims processing;

(ii) Cost report settlement processes;

(iii) Audits; and

(iv) Investigation of false claims, fraud, or prohibited business relationships.

(F) For provider service delivery:

(i) Provider licensing or certification required responsibilities and activities; and

(ii) Specific service monitoring and evaluation activities provided in program-specific rules or Department policy.

(c) The following may engage in program integrity activities including but not limited to general monitoring of the provider's performance in service delivery, reviewing a request for services, or auditing a claim of services, before or after payment, for assurance that the specific care or service was provided in accordance with the program-specific rules and the generally accepted standards of performance:

(A) Department staff or designees, including staff of a CDDP or brokerage; and

(B) Federal or state oversight authority.

(d) Payment may be denied or may be subject to recovery if the review or audit determines the service was not provided in accordance with provider rules, program-specific rules, provider enrollment agreements or contracts, or does not meet the criteria for quality or appropriateness of the service or payment.

(e) If the Department or other federal or state oversight authorities determine that an overpayment has been made to a provider, the amount of overpayment is subject to recovery.

(f) The provider may face other sanctions or penalties, including termination of provider enrollment agreements or contracts as allowed by program-specific or Department rules.

(g) The Department may communicate with and coordinate any program integrity actions with the MFCU, USDHHS, other federal or state oversight authorities including law enforcement, or Department designees including CDDPs and brokerages.

Stat. Auth.: ORS 409.050, 410.070, 411.060, ~~&~~ 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610~~-to~~ 430.695, ~~&~~ 443.400~~-to~~ 443.455

411-370-0030 Provider Enrollment

(1) For the purpose of this rule, all providers of community services programs, authorized to utilize the eXPRS, SFMA, or MMIS, ~~or CPMS systems~~, and licensed or certified by Department rules, or otherwise qualified by program-specific rules, prior to July 1, 2011 shall be deemed to be an enrolled provider as of July 1, 2011, subject to all provisions of these rules.

(2) Being an enrolled provider is a condition of eligibility for a Department payment for claims in community services programs. The Department requires billing providers to be enrolled as providers consistent with the

provider enrollment processes set forth in this rule. If payment for community services program services shall be made under a contract with the Department or the Department's designees, including CDDPs, the provider must also meet the contract requirements. Contract requirements are separate from the requirements of these provider enrollment rules.

(3) Enrollment as a provider with the Department is not a promise that the enrolled provider shall receive any minimum amount of work from the Department, or the Department's designees, including CDDPs.

(4) RELATION TO SERVICE ELEMENT STANDARDS AND PROCEDURES, PROGRAM-SPECIFIC RULES, PROVIDER ENROLLMENT AGREEMENT, OR CONTRACT REQUIREMENTS. Provider enrollment establishes essential provider participation requirements for becoming an enrolled provider for the Department. The details of provider qualification requirements, recipient eligibility, covered services, how to obtain service authorization, documentation requirements, claims submission, available electronic access instructions, and other pertinent instructions and requirements are contained in the service element standards and procedures, program-specific rules, or provider enrollment agreement or contract.

(5) CRITERIA FOR ENROLLMENT. To be enrolled ~~after July 1, 2011~~ providers must:

(a) Meet the requirements, if applicable, of the statewide agency certification process as prescribed in OAR chapter 411, division 323.

(b) Meet all program-specific requirements identified in service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts in addition to the requirements identified in these rules;

(c) Meet Department licensing, certification, or service endorsement requirements for the type of community services programs the provider shall deliver as described in the program-specific rules, provider enrollment agreements, or contracts; and

(d) Obtain a Medicaid Agency Identification Number and applicable Medicaid Performing Provider Number from the Department for the specific services for which the provider is enrolling.

(6) PARTICIPATION AS AN ENROLLED PROVIDER. Participation with the Department as an enrolled provider is open to qualified providers that:

(a) Meet the qualification requirements established in these rules and program-specific rules, provider enrollment agreements, or contracts;

(b) Enroll as a provider with the Department in accordance with these rules;

(c) Provide or shall provide a covered service within their scope of licensure, certification, or service endorsement, if applicable, to an eligible recipient in accordance with service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts; and

(d) Accept the payment amounts established in accordance with the Department's program-specific payment structures, service element standards and procedures, program-specific rules, provider enrollment agreements, or contracts for services providers.

(7) ENROLLMENT PROCESS. To be enrolled as a provider with the Department, an individual or organization must submit a complete and accurate provider enrollment form, provider disclosure form, and provider enrollment agreement, available from the Department.

(a) PROVIDER ENROLLMENT REQUEST FORM. The provider enrollment form requests basic demographic information about the provider that shall be permanently associated with the provider or organization until changed on an updated form. For the purpose of provider enrollment, the Department may use, instead of the provider enrollment form required under these rules, the application for certification required under OAR chapter 411, division 323 if such an application is applicable to the provider.

(b) PROVIDER DISCLOSURE FORM. All individuals and entities are required to disclose information used by the Department to determine

whether an exclusion applies that would prevent the Department from enrolling the provider. Individual performing providers must submit a disclosure statement. All providers that are enrolling as an entity (corporation, non-profit, partnership, sole proprietorship, governmental) must submit a disclosure of ownership and control interest statement. For the purpose of provider enrollment, the Department may use, instead of the provider disclosure form required under these rules, the application for certification required under OAR chapter 411, division 323 if such an application is applicable to the provider.

(A) Entities must disclose all the information required on the disclosure of ownership and control interest statement.

(B) Payment may not be made to any individual or entity that has been excluded from participation in federal or state programs or that employs or is managed by excluded individuals or entities.

(C) The Department may refuse to enter into or may suspend or terminate a provider enrollment agreement if the individual performing provider or any individual who has an ownership or control interest in the entity, or who is an agent or managing employee of the provider, has been sanctioned or convicted of a criminal offense related to that individual's involvement in any program established under Medicare, Medicaid, Title XIX services, or other public assistance program.

(D) The Department may refuse to enter into or may suspend or terminate a provider enrollment agreement or contract for provider services, if the Department determines that the provider did not fully and accurately make any disclosure required under this rule.

(8) PROVIDER ENROLLMENT AGREEMENT. The provider must sign the provider enrollment agreement and submit it to the Department for review at the time the provider submits the provider enrollment form and related documentation. Signing the provider enrollment agreement constitutes agreement by a provider to comply with all applicable Department service element standards and procedures, provider and program rules, and

applicable federal and state laws and regulations in effect on the date of service. The provider enrollment agreement must be submitted even if alternatives to submitting the provider enrollment form and provider disclosure form are used, as provided in sections (7)(a) and (7)(b) of this rule.

(9) ENROLLMENT OF PROVIDERS. A provider shall be enrolled, assigned, and issued a Medicaid Agency Identification Number and Medicaid Performing Provider Number upon the following criteria:

(a) Provider submission, consistent with Department procedures, of a completed and signed provider enrollment form, provider disclosure form, provider enrollment agreement, any applicable provider licensure, certification, or service endorsement materials, and all other required documents to the Department.

(b) Provider signature on required forms must be the provider or an individual with actual authority for the provider to legally bind the provider to attest and certify to the accuracy and completeness of the information submitted.

(c) The provisions of this rule, OAR chapter 411, division 323 if applicable, program-specific rules, service element standards and procedures, provider enrollment agreements, or contracts relating to provider qualifications, certification, licensure, and service endorsement are completed.

(10) Provider enrollment is not complete until all required information has been submitted, verified, and the Medicaid Agency Identification Number and the Medicaid Performing Provider Number are issued.

(11) CLAIM OR ENCOUNTER SUBMISSION. Submission of a claim or encounter or other payment request document constitutes the enrolled provider's agreement that:

(a) The service was provided in compliance with all applicable rules and requirements in effect on the date of service;

(b) The provider has created and maintained all records necessary to disclose the extent of services provided and provider's compliance

with applicable program and financial requirements, and that the provider agrees to make such information available upon request to the Department or the Department's designees including CDDPs, brokerages, the MFCU (for Medicaid-funded services), the Oregon Secretary of State, and (for federally-funded services) the federal funding authority and the Comptroller General of the United States;

(c) The information on the claim or encounter, regardless of the format or other payment document, is true, accurate, and complete; and

(d) The provider understands that payment of the claim or encounter or other payment document shall be from federal or state funds, or a combination of federal and state funds, and that any falsification, or concealment of a material fact, may result in prosecution under federal and state laws.

(12) Medicaid Agency Identification Numbers and Medicaid Performing Provider Numbers shall be specific to the provider, and the service sites, locations, or type of service authorized by the Department or the Department's designee including CDDPs and support services brokerages. Issuance of a Department-assigned Medicaid Agency Identification Number and Medicaid Performing Provider Number establishes enrollment of an individual or organization as a provider for community services programs.

(13) Providers must provide the following updates:

(a) An enrolled provider must notify the Department in writing of a material change in any status or condition on any element of their provider enrollment form. Providers must notify the Department of the following changes in writing within 30 calendar days:

(A) Business affiliation;

(B) Ownership;

(C) Federal tax identification number;

(D) Ownership and control information; or

(E) Criminal convictions.

(b) Claims submitted by, or payments made to, providers who have not timely furnished the notification of changes or have not submitted any of the items that are required due to a change may be denied payment or payment may be subject to recovery.

(14) The provider enrollment agreement may be terminated as follows:

(a) PROVIDER TERMINATION REQUEST.

(A) The provider may ask the Department to terminate the provider enrollment agreement upon the following conditions and timelines unless otherwise required by service element standards and procedures, program-specific rules, or provider enrollment agreement or contract.

(i) Upon the provider's convenience with at least 90 days advance written notice; or

(ii) Upon a minimum of 30 days advance written notice if the Department does not meet the obligations under these rules and such dispute remains unresolved at the end of the 30 day period or such longer period, if any, as specified by the provider in the notice.

(B) The request must be in writing, signed by the provider, and mailed or delivered to the Department. The notice must specify the Department-assigned Medicaid Agency Identification Number and Medicaid Performing Provider Number, if known.

(C) When accepted, the Department shall assign the Medicaid Agency Identification Number and Medicaid Performing Provider Number a termination status and the effective date of the termination status.

(D) Termination of the provider enrollment agreement does not relieve the provider of any obligations for covered services provided under these rules in effect for dates of services during which the provider enrollment agreement was in effect.

(b) DEPARTMENT TERMINATION. Pursuant to the provisions of OAR chapter 407, division 120, the Department may terminate the provider enrollment agreement immediately upon notice to the provider, or a later date as the Department may establish in the notice, upon the occurrence of any of the following events:

(A) The Department fails to receive funding, appropriations, limitations, or other expenditure authority at levels that the Department or the specific program determines to be sufficient to pay for the services covered under the agreement;

(B) Federal or state laws, regulations, or guidelines are modified or interpreted by the Department in a such a way that either providing the services under the agreement is prohibited or the Department is prohibited from paying for such services from the planned funding source;

(C) The Department has issued a final order revoking the Department-assigned Medicaid Agency Identification Number, service endorsement, or Medicaid Performing Provider Number based on a sanction;

(D) The provider no longer holds a required license, certificate, service endorsement, or other authority to qualify as a provider. The termination shall be effective on the date the license, certificate, service endorsement, or other authority is no longer valid.

(c) In the event of any termination of the provider enrollment agreement, the provider's sole monetary remedy is limited to covered services the Department determines to be compensable under the provider agreement, a claim for unpaid invoices, hours worked within any limits set forth in the agreement but not yet billed, and Department-authorized expenses incurred prior to termination. Providers are not entitled to recover indirect or consequential damages. Providers are not entitled to attorney fees, costs, or other expenses of any kind.

(15) IMMEDIATE SUSPESION. When a provider fails to meet one or more of the requirements governing participation as a Department enrolled provider, the provider's Department-assigned Medicaid Agency Identification Number or Medicaid Performing Provider Number may be immediately suspended consistent with the provisions of OAR chapter 407, division 120. The provider may not provide services to recipients during a period of suspension. The Department shall deny claims for payment or other payment requests for dates of service during a period of suspension.

(16) The provision of a program-specific provider enrollment agreement or contract covered services to eligible recipients is voluntary on the part of the provider. Providers are not required to serve all recipients seeking service.

(17) The provider performs all services as an independent contractor. The provider is not an officer, employee, or agent of the Department.

(18) The provider is responsible for its employees and for providing employment-related benefits and deductions that are required by law. The provider is solely responsible for its acts or omissions including the acts or omissions of its own officers, employees, or agents. The Department's responsibility shall be limited to the Department's authorization and payment obligations for covered services provided in accordance with these rules.

Stat. Auth.: ORS 409.050, 410.070, 411.060, ~~&~~ 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610~~ to~~ 430.695, ~~&~~ 443.400~~ to~~ 443.455

411-370-0040 Variances

(1) The Department may grant a variance to these rules based upon a demonstration by the provider that an alternative method or different approach provides equal or greater effectiveness and does not adversely impact the welfare, health, safety, or rights of individuals or violate state or federal laws.

(2) The provider requesting a variance must submit, in writing, an application on a Department approved form that contains the following:

(a) The section of the rule from which the variance is sought;

(b) The reason for the proposed variance; and

(c) The alternative practice, service, method, concept, or procedure proposed.

(3) The Department shall approve or deny the request for a variance. In reviewing the variance request, the Department may seek input or information from the Department's designees, including CDDPs and brokerages.

(4) The Department's decision shall be sent to the provider and to all relevant Department programs or offices within 30 calendar days of the receipt of the variance request.

(5) The provider may appeal the denial of a variance request by sending a written request for review to the Administrator, whose decision is final.

(6) The Department shall determine the duration of the variance.

(7) The provider may implement a variance only after written approval from the Department.

Stat. Auth.: ORS 409.050, 411.060, 410.070, 430.640
Stats. Implemented: ORS 427.005, 427.007, 430.215, 430.610-430.695, 443.400-443.455