

**DEPARTMENT OF HUMAN SERVICES  
DEVELOPMENTAL DISABILITIES  
OREGON ADMINISTRATIVE RULES**

**CHAPTER 411  
DIVISION 350**

**MEDICALLY FRAGILE CHILDREN'S SERVICES**

**411-350-0010 Statement of Purpose**

*(Amended 12/28/2013)*

(1) The rules in OAR chapter 411, division 350 establish the policy of, and prescribe the standards and procedures for, the provision of medically fragile children's (MFC) services. These rules are established to ensure that MFC services augment and support independence, empowerment, dignity, and development of medically fragile children through the provision of flexible and efficient services to eligible families.

(2) MFC services are exclusively intended to enable a child who is medically fragile to have a permanent and stable familial relationship. MFC services are intended to supplement the natural supports and services provided by a child's family and provide the support necessary to enable the family to meet the needs of caring for a medically fragile child.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

**411-350-0020 Definitions**

*(Amended 12/28/2013)*

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 350:

(1) "Abuse" means "abuse" of a child as defined in ORS 419B.005.

(2) "Activities of Daily Living (ADL)" means basic personal everyday activities, including but not limited to tasks such as eating, using the restroom, grooming, dressing, bathing, and transferring.

- (3) "ADL" means "activities of daily living" as defined in this rule.
- (4) "Aide" means a non-licensed caregiver who may, or may not, be a certified nursing assistant.
- (5) "Attendant Care" means Medicaid state plan funded essential supportive daily care described in OAR 411-350-0050 that is delivered by a qualified provider to enable a child to remain in, or return to, the child's family home.
- (6) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210.
- (7) "Behavior Consultant" means a contractor with specialized skills who develops a Behavior Support Plan.
- (8) "Behavior Support Plan" means the written strategy based on person-centered planning and a functional assessment that outlines specific instructions for a provider to follow to cause a child's challenging behaviors to become unnecessary and to change the provider's own behavior, adjust environment, and teach new skills.
- (9) "Billing Provider" means an organization that enrolls and contracts with the Department to provide services through employees that bills the Department for the provider's services.
- (10) "Case Management" means the functions performed by a services coordinator. Case management includes determining service eligibility, developing a plan of authorized services, and monitoring the effectiveness of services and supports.
- (11) "Child" means an individual who is less than 18 years of age applying for, or eligible for, medically fragile children's services.
- (12) "Chore Services" mean the services described in OAR 411-350-0050 that are needed to restore a hazardous or unsanitary situation in a child's family home to a clean, sanitary, and safe environment.

(13) "Clinical Criteria (Form DHS-0519)" means the assessment tool used by the Department to evaluate the intensity of the challenges and care needs of medically fragile children.

(14) "Community First Choice (K Plan)" means Oregon's state plan amendment authorized under section 1915(k) of the Social Security Act.

(15) "Community Nursing Services" mean the services described in OAR 411-350-0050 that include nurse delegation, training, and care coordination for a child living in the child's family home.

(16) "Community Transportation" means the services described in OAR 411-350-0050 that enable a child to gain access to community services, activities, and resources that are not medical in nature.

(17) "Cost Effective" means that in the opinion of a services coordinator, a specific service, support, or item of equipment meets a child's service needs and costs less than, or is comparable to, other similar service, support, or equipment options considered.

(18) "Day" means a calendar day unless otherwise specified in these rules.

(19) "Delegation" means that a registered nurse authorizes an unlicensed person to perform nursing tasks and confirms that authorization in writing. Delegation may occur only after a registered nurse follows all steps of the delegation process as outlined in OAR chapter 851, division 047. Delegation by a physician is also allowed.

(20) "Department" means the Department of Human Services.

(21) "Developmental Disability" means a neurological condition that originates in the developmental years, that is likely to continue, and significantly impacts adaptive behavior as diagnosed and measured by a qualified professional as described in OAR 411-320-0080.

(22) "Direct Nursing Services" mean the nursing services described in OAR 411-350-0050 that are determined medically necessary to support a child receiving medically fragile children's services in the child's family home.

(23) "Director" means the director of the Department's Office of Developmental Disability Services or the director's designee.

(24) "Environmental Accessibility Adaptations" mean the physical adaptations described in OAR 411-350-0050 that are necessary to ensure the health, welfare, and safety of a child in the child's family home, or that enable a child to function with greater independence in the family home.

(25) "Family" means a unit of two or more people that includes at least one child with an intellectual or developmental disability where the child's primary caregiver is:

(a) Related to the child with an intellectual or developmental disability by blood, marriage, or legal adoption; or

(b) In a domestic relationship where partners share:

(A) A permanent residence;

(B) Joint responsibility for the household in general, such as child-rearing, maintenance of the residence, and basic living expenses; and

(C) Joint responsibility for supporting a child with an intellectual or developmental disability when the child is related to one of the partners by blood, marriage, or legal adoption.

(26) "Family Home" means a child's primary residence that is not under contract with the Department to provide services as a certified foster home or a licensed or certified residential care facility, assisted living facility, nursing facility, or other residential support program site.

(27) "Family Training" means the training and counseling services described in OAR 411-350-0050 that are provided to a child's family to increase the family's capacity to care for, support, and maintain the child in the child's family home.

(28) "Founded Reports" means the Department's or Law Enforcement Authority's (LEA) determination, 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.

(29) "Functional Needs Assessment" means a comprehensive assessment that documents:

(a) Physical, mental, and social functioning; and

(b) Risk factors, choices and preferences, service and support needs, strengths, and goals.

(30) "Grievance" means a process by which a person may air complaints and seek remedies.

(31) "Home and Community-Based Waiver Services" mean the services approved by the Centers for Medicare and Medicaid Services in accordance with section 1915(c) and 1115 of the Social Security Act.

(32) "Hospital Model Waiver" means the waiver program granted by the federal Centers for Medicare and Medicaid Services that allows Title XIX funds to be spent on children living in the family home who otherwise would have to be served in a hospital if the waiver program was not available.

(33) "IADL" means "instrumental activities of daily living" as defined in this rule.

(34) "ICF/MR" means intermediate care facilities for the mentally retarded. Federal law and regulations use the term "intermediate care facilities for the mentally retarded (ICF/MR)". The Department prefers to use the accepted term "individual with intellectual disability (ID)" instead of "mental retardation (MR)". However, as ICF/MR is the abbreviation currently used in all federal requirements, ICF/MR is used.

(35) "Individual Support Plan (ISP)" means the written details of the supports, activities, and resources required for a child to achieve and maintain personal outcomes. The ISP is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. Individual support needs are identified through a functional needs assessment. The manner in which services are delivered, service providers, and the frequency of services are

reflected in an ISP. The ISP is the child's plan of care for Medicaid purposes and reflects whether services are provided through a waiver, state plan, or natural supports.

(36) "Instrumental Activities of Daily Living (IADL)" means the activities other than activities of daily living, including but not limited to:

- (a) Meal planning and preparation;
- (b) Budgeting;
- (c) Shopping for food, clothing, and other essential items;
- (d) Performing essential household chores;
- (e) Communicating by phone or other media; and
- (f) Traveling around and participating in the community.

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

(38) "ISP" means "Individual Support Plan" as defined in this rule.

(39) "K Plan" means "Community First Choice" as defined in this rule.

(40) "Level of Care" means a child meets the following hospital level of care:

- (a) The child has a documented medical condition and demonstrates the need for active treatment as assessed by the clinical criteria; and
- (b) The child's medical condition requires the care and treatment of services normally provided in an acute medical hospital.

(41) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who comes in contact with and has reasonable cause to believe a child with or without an intellectual or developmental disability has suffered abuse, or comes in contact with any person whom the official has reasonable cause to believe abused a child with or without an

intellectual or developmental disability, regardless of whether or not the knowledge of the abuse was gained in the reporter's official capacity. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this section, 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.

(42) "Medically Fragile Children (MFC)" means children who have a health impairment that requires long term, intensive, specialized services on a daily basis, who have been found eligible for medically fragile children's services by the Department.

(43) "Medically Fragile Children's Unit (MFCU)" means the program for medically fragile children's services administered by the Department.

(44) "MFC" means "medically fragile children" as defined in this rule.

(45) "MFCU" means "medically fragile children's unit" as defined in this rule.

(46) "Natural Supports" means the parental responsibilities for a child who is less than 18 years of age and the voluntary resources available to the child from the child's relatives, friends, neighbors, and the community that are not paid for by the Department.

(47) "Nurse" means a person who holds a current license from the Oregon Board of Nursing as a registered nurse (RN) or licensed practical nurse (LPN) pursuant to ORS chapter 678.

(48) "Nursing Care Plan" means the plan developed by a nurse that describes the medical, nursing, psychosocial, and other needs of a child and how those needs are met. The Nursing Care Plan includes the tasks that are taught or delegated to the child's primary caregiver or a qualified provider. When a Nursing Care Plan exists, it is a supporting document for an Individual Support Plan.

(49) "Nursing Tasks or Services" mean the care or services that require the education and training of a licensed professional nurse to perform. Nursing tasks or services may be delegated.

(50) "OHP" means the Oregon Health Plan.

(51) "Oregon Intervention System" means the system of providing training to people who work with designated individuals to provide elements of positive behavior support and non-aversive behavior intervention. The Oregon Intervention System uses principles of pro-active support and describes approved protective physical intervention techniques that are used to maintain health and safety.

(52) "OSIP-M" means "Oregon Supplemental Income Program-Medical" as defined in OAR 461-101-0010. OSIP-M is Oregon Medicaid insurance coverage for individuals who meet the eligibility criteria described in OAR chapter 461.

(53) "Parent" means biological parent, adoptive parent, stepparent, or legal guardian.

(54) "Person-Centered Planning":

(a) Means a timely and formal or informal process for gathering and organizing information that helps --

(A) Determine and describe choices about personal goals, activities, services, providers, 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.

(b) The methods for gathering information vary, but all are consistent with cultural considerations, needs, and preferences.

(55) "Personal Care Services" means assistance with activities of daily living, instrumental activities of daily living, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding.

(56) "Plan of Care" means the written plan of Medicaid services required by Medicaid regulation. Oregon's plan of care is the Individual Support Plan.

(57) "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 intervention possible;

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

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

(58) "Primary Caregiver" means a child's parent, guardian, relative, or other non-paid parental figure that provides direct care at the times that a paid provider is not available.

(59) "Protective Physical Intervention" means any manual physical holding of, or contact with, a child that restricts the child's freedom of movement

(60) "Provider" means a person who is qualified as described in OAR 411-350-0080 to receive payment from the Department for providing support and services to a child according to the child's Individual Support Plan. A provider works directly with a medically fragile child. A provider may be an employee of a billing provider, employee of a child's parent, or an independent contractor.

(61) "Relief Care" means the intermittent services described in OAR 411-350-0050 that are provided on a periodic basis of not more than 14 consecutive days for the relief of, or due to the temporary absence of, a child's primary caregiver.

(62) "Service Level" means the services allotted for the care of a child based on the clinical criteria. The service level consists of state plan services, including Community First Choice state plan services, and if the

child is on a waiver, waiver services. Service levels increase or decrease in direct relationship to the increasing or decreasing clinical criteria score.

(63) "Services Coordinator" means an employee of the Department who ensures a child's eligibility for medically fragile children's services and provides assessment, case management, service implementation, and evaluation of the effectiveness of the services. A services coordinator is a child's person-centered plan coordinator as defined in the Community First Choice state plan.

(64) "Special Diet" means the specially prepared food or particular types of food described in OAR 411-350-0050 that are specific to a child's medical condition or diagnosis and needed to sustain the child in the child's family home.

(65) "Specialized Equipment and Supplies" means the devices, aids, controls, supplies, or appliances described in OAR 411-350-0050 that enable a child to increase the child's ability to perform activities of daily living or to perceive, control, or communicate with the environment in which the child lives.

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

(67) "Supplant" means take the place of.

(68) "Support" means the assistance that a child and the child's family requires, solely because of the effects of the child's intellectual or developmental disability or medical condition, to maintain or increase the child's age-appropriate independence, achieve a child's age-appropriate community presence and participation, and to maintain the child in the child's family home. Support is subject to change with time and circumstances.

(69) "These Rules" mean the rules in OAR chapter 411, division 350.

(70) "Volunteer" means any person providing services without pay to support the services and supports provided to a child.

(71) "Waiver Services" means the menu of disability related services and supplies, exclusive of attendant care and the Oregon Health Plan, that are specifically identified by the Title XIX Centers for Medicare and Medicaid Services Waiver.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

### **411-350-0030 Eligibility**

*(Amended 12/28/2013)*

#### (1) ELIGIBILITY.

(a) In order to be eligible for MFC services, a child must:

(A) Be under the age of 18;

(B) Be a U.S. citizen;

(C) Be eligible for OSIP-M;

(D) Be eligible to receive Title XIX (Medicaid) or Title XXI (CHIPS) services;

(E) After completion of an assessment, meet the level of care as defined in OAR 411-350-0020;

(F) Be accepted by the Department by scoring 50 or greater on the clinical criteria and have a status of medical need that is likely to last for more than two months;

(G) Reside in the family home; and

(H) Be capable of being safely served in the family home. This includes but is not limited to the child's primary caregiver demonstrating the willingness, skills, and ability to provide direct care not paid for in a child's Individual Support Plan, as determined by the services coordinator within the limitations of OAR 411-350-0050.

(b) A child that resides in a foster home that meets the eligibility criteria in subsection (a)(A) to (F) of this section is eligible for direct nursing services as described in OAR 411-350-0050.

(2) INELIGIBILITY. A child is not eligible for MFC services if the child:

(a) Resides in a hospital, school, sub-acute facility, nursing facility, intermediate care facility for individuals with intellectual or developmental disabilities (formerly referred to as ICF/MR), residential facility, or other institution. A child that resides in a foster home is eligible for only direct nursing services as described in OAR 411-350-0050;

(b) Does not require waiver services, Community First Choice state plan services, or has sufficient family, government, or community resources available to provide for his or her care; or

(c) Is not safely served in the family home as described in section (1)(h) of this rule.

(3) REDETERMINATION. The Department redetermines a child's eligibility for MFC services using the clinical criteria at a minimum of every six months, or as the child's status changes.

(4) TRANSITION. A child who meets the following criteria must begin a transition period to phase out of MFC services within 60 days and at the end of the 60 days transition period, is no longer eligible to receive MFC services:

(a) The child has been previously eligible for MFC services;

(b) The needs of the child have decreased; and

(c) The score on the clinical criteria remains at less than 30 during the transition period.

(5) WAIT LIST. If the allowable number of children on the Hospital Model Waiver are already receiving services, the Department may place a child eligible for MFC services on a wait list, based on the date of referral. A child

on the wait list may access other waiver, state plan personal care, or Community First Choice state plan services as determined eligible.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

### **411-350-0040 Individual Support Plan**

*(Amended 12/28/2013)*

(1) To develop an ISP, a services coordinator must complete a functional needs assessment using a person-centered planning approach and assess the service needs of the child. The assessment must take place in person and the services coordinator must interview the child's parent, other caregivers, and when appropriate any other person at the parent's request. The assessment must identify the following:

- (a) The services for which the child is currently eligible;
- (b) The services currently being provided; and
- (c) All available family, private health insurance, and government or community resources that meet any, some, or all of the child's needs.

(2) The services coordinator must prepare, with the input of the child's parent and any other person at the parent's request, a written ISP that identifies:

- (a) The service needs of the child;
- (b) The most cost effective services for safely and appropriately meeting the child's service needs; and
- (c) The methods, resources, and strategies that address the child's service needs.

(3) The ISP must include:

- (a) A description of the supports required, including the reason the support is necessary. The description must be consistent with the needs identified in the functional needs assessment;

(b) A list of personal, community, and public resources that are available to the child and how the resources may be applied to provide the required supports. Sources of support may include waiver services, state plan services, or natural supports;

(c) The maximum hours of provider services authorized for the child;

(d) The annual service level;

(e) The number of hours of MFC services authorized for the child;

(f) Additional services authorized by the Department for the child; and

(g) The estimated number of hours that an aide is authorized and the number of hours that a licensed nurse is authorized;

(A) RN hours are not authorized when an LPN may safely perform the duties.

(B) RN or LPN hours are not authorized when an aide may safely perform the duties.

(h) The projected date of when specific services are to begin and end, as well as the end date, if any, of the period of service covered by the ISP;

(i) Projected costs with sufficient detail to support estimates;

(j) The manner in which services are delivered and the frequency of services;

(k) Service providers;

(l) The child's strengths and preferences;

(m) If the child has a determined service level, the clinical and support needs as identified through the functional needs assessment;

(n) Individually identified goals and desired outcomes;

(o) The services and supports (paid and unpaid) to assist the child to achieve identified goals and the providers of the services and supports, including voluntarily provided natural supports;

(p) The risk factors and the measures in place to minimize the risk factors, including back-up plans;

(q) The identity of the person responsible for case management and monitoring the ISP;

(r) The date of the next ISP review that, at a minimum, must be completed within 12 months of the last ISP or more frequently if the child's medical status changes;

(s) The Nursing Care Plan as a supporting document, when one exists;

(t) A provision to prevent unnecessary or inappropriate care; and

(u) If the child has a determined service level, any changes in support needs identified through a functional needs assessment.

(4) The child's parent must review the ISP prior to implementation. The parent and the services coordinator must sign the ISP and a copy must be provided to the parent.

(5) A services coordinator must reflect significant changes in the needs of a child in the ISP, as they occur, and provide a copy of the revised ISP to the child's parent.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

### **411-350-0050 Scope and Limitations of Medically Fragile Children's Services**

*(Amended 12/28/2013)*

(1) MFC services are intended to support, not supplant, the natural supports supplied by a child's primary caregiver. MFC services are not

available to replace services provided by a primary caregiver or to replace other governmental or community services.

(2) The Department only authorizes MFC services to enable a child's primary caregiver to meet the needs of caring for a child on the Hospital Model Waiver. All MFC services funded by the Department must be based on the actual and customary costs related to best practice standards of care for children with similar disabilities.

(3) When multiple children in the same family home or setting qualify for MFC services, the same primary caregiver must provide services to all qualified children if services may be safely delivered by a single primary caregiver, as determined by the services coordinator.

(4) For an initial or annual ISP, MFC services may include a combination of the following waiver and other Medicaid services based upon the needs of a child as determined by a services coordinator and as consistent with the child's functional needs assessment:

(a) Community First Choice state plan services:

(A) Specialized consultation, including behavior consultation as described in section (5) of this rule;

(B) Community nursing services as described in section (6) of this rule;

(C) Environmental accessibility adaptations as described in section (7) of this rule;

(D) Attendant care as described in section (8) of this rule;

(E) Relief care as described in section (9) of this rule;

(F) Specialized equipment and supplies as described in section (10) of this rule;

(G) Chore services as described in section (11) of this rule; and

(H) Community transportation as described in section (12) of this rule.

(b) Waiver services:

(A) Family training as described in section (13) of this rule;

(B) Special diet as described in section (14) of this rule; and

(C) Translation as described in section (15) of this rule.

(c) State plan services - Direct nursing services as described in section (16) of this rule.

**(5) SPECIALIZED CONSULTATION – BEHAVIOR CONSULTATION.**

Behavior consultation is only authorized to support a child's primary caregiver in their caregiving role. Behavior consultation is only authorized, as needed, to respond to specific problems identified by a primary caregiver or a services coordinator. Behavior consultants must:

(a) Work with the child's primary caregiver to identify:

(A) Areas of a child's family home life that are of most concern for the child and the child's parent;

(B) The formal or informal responses the child's family or the provider has used in those areas; and

(C) The unique characteristics of the child's family that may influence the responses that may work with the child.

(b) Assess the child. The assessment must include:

(A) Specific identification of the behaviors or areas of concern;

(B) Identification of the settings or events likely to be associated with, or to trigger, the behavior;

(C) Identification of early warning signs of the behavior;

(D) Identification of the probable reasons that are causing the behavior and the needs of the child that are being met by the behavior, including the possibility that the behavior is:

- (i) An effort to communicate;
- (ii) The result of a medical condition;
- (iii) The result of an environmental cause; or
- (iv) The symptom of an emotional or psychiatric disorder.

(E) Evaluation and identification of the impact of disabilities (i.e. autism, blindness, deafness, etc.) that impact the development of strategies and affect the child and the area of concern; and

(F) An assessment of current communication strategies.

(c) Develop a variety of positive strategies that assist the child's primary caregiver and the provider to help the child use acceptable, alternative actions to meet the child's needs in the most cost effective manner. These strategies may include changes in the physical and social environment, developing effective communication, and appropriate responses by a primary caregiver and provider to the early warning signs.

(A) Interventions must be done in accordance with positive behavioral theory and practice as defined in OAR 411-350-0020.

(B) The least intrusive intervention possible must be used.

(C) Abusive or demeaning interventions must never be used.

(D) The strategies must be adapted to the specific disabilities of the child and the style or culture of the child's family.

(d) Develop emergency and crisis procedures to be used to keep the child and the child's primary caregiver and the provider safe. When interventions in the behavior of the child are necessary, positive,

preventative, non-aversive interventions that conform to the Oregon Intervention System must be utilized;

(e) Develop a written Behavior Support Plan using clear, concrete language that is understandable to the child's primary caregiver and the provider that describes the assessment, strategies, and procedures to be used;

(f) Teach the child's primary caregiver and the provider the strategies and procedures to be used; and

(g) Monitor and revise the Behavior Support Plan as needed.

#### (6) COMMUNITY NURSING SERVICES.

(a) Community nursing services include:

(A) Evaluation, including medication reviews, and identification of supports that minimize health risks while promoting a child's autonomy and self-management of healthcare;

(B) Collateral contact with a services coordinator regarding a child's community health status to assist in monitoring safety and well-being and to address needed changes to the child's ISP; and

(C) Delegation and training of nursing tasks to a child's primary caregiver and a provider so the caregivers may safely perform health related tasks.

(b) Community nursing services exclude direct nursing care.

(c) Community nursing services are not covered by other Medicaid spending authorities.

(7) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS. Environmental accessibility adaptations are physical adaptations to a child's family home that are necessary to ensure the health, welfare, and safety of the child in the family home due to the child's medical condition or intellectual or developmental disability or that are necessary to enable the child to

function with greater independence around the family home and in family activities.

(a) Environmental accessibility adaptations include but are not limited to:

(A) An environmental modification consultation to determine the appropriate type of adaptation to ensure the health, welfare, and safety of the child;

(B) Installation of shatter-proof windows;

(C) Hardening of walls or doors;

(D) Specialized, hardened, waterproof, or padded flooring;

(E) An alarm system for doors or windows;

(F) Protective covering for smoke alarms, light fixtures, and appliances;

(G) Sound and visual monitoring systems;

(H) Fencing;

(I) Installation of ramps, grab-bars, and electric door openers;

(J) Adaptation of kitchen cabinets and sinks;

(K) Widening of doorways;

(L) Handrails;

(M) Modification of bathroom facilities;

(N) Individual room air conditioners for a child whose temperature sensitivity issues create behaviors or medical conditions that put the child or others at risk;

(O) Installation of non-skid surfaces;

(P) Overhead track systems to assist with lifting or transferring;

(Q) Specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the child;

(R) Modifications for the primary vehicle used by the child that are necessary to meet the unique needs of the child and ensure the health, welfare, and safety of the child, such as lift, interior alterations to seats, head and leg rests, belts, special safety harnesses, or other unique modifications to keep the child safe in the vehicle; and

(S) Adaptations to control lights, heat, stove, etc.

(b) Environmental accessibility adaptations exclude:

(A) Adaptations or improvements to the child's family home that are of general utility and are not for the direct safety, remedial, or long term benefit to the child;

(B) Adaptations that add to the total square footage of the child's family home; and

(C) General repair or maintenance and upkeep required for the child's family home or motor vehicle, including repair of damage caused by the child.

(c) Environmental accessibility adaptations are limited to \$5,000 per modification. A services coordinator may request approval for additional expenditures through the Department prior to expenditure. Approval is based on the child's service needs and goals and the Department's determination of appropriateness and cost-effectiveness.

(d) Environmental accessibility adaptations must be tied to supporting ADL, IADL, and health-related tasks as identified in the child's ISP.

(e) Environmental accessibility adaptations over \$500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected by a local inspector and certified as in compliance with local codes. Certification of compliance must be filed in the provider's file prior to payment.

(f) Environmental accessibility adaptations must be made within the existing square footage of the child's family home, except for external ramps, and may not add to the square footage of the building.

(g) Payment to the contractor is to be withheld until the work meets specifications.

(h) Environmental accessibility adaptations that are provided in a rental structure must be authorized in writing by the owner of the structure prior to initiation of the work. This does not preclude any reasonable accommodations required under the Americans with Disabilities Act.

(8) ATTENDANT CARE. Attendant care services include the purchase of direct provider support provided to a child in the family home or community by qualified individual providers and agencies. Provider assistance provided through attendant care must support the child to live as independently as appropriate for the child's age, support the child's family in their primary caregiver role, and be based on the identified needs of the child. A child's primary caregiver is expected to be present or available during the provision of attendant care.

(a) Attendant care services provided by qualified providers or agencies include:

(A) Basic personal hygiene - Assistance with bathing and grooming;

(B) Toileting, bowel, and bladder care - Assistance in the bathroom, diapering, external cleansing of perineal area, and care of catheters;

(C) Mobility - Transfers, comfort, positioning, and assistance with range of motion exercises;

- (D) Nutrition - Feeding and monitoring intake and output;
- (E) Skin care - Dressing changes;
- (F) Physical healthcare including delegated nursing tasks;
- (G) Supervision - Providing an environment that is safe and meaningful for the child and interacting with the child to prevent danger to the child and others and maintain skills and behaviors required to live in the child's family home and community;
- (H) Assisting the child with appropriate leisure activities to enhance development in the child's family home and community and provide training and support in personal environmental skills;
- (I) Communication - Assisting the child in communicating, using any means used by the child;
- (J) Neurological - Monitoring of seizures, administering medication, and observing status; and
- (K) Accompanying the child and the child's family to health related appointments.

(b) Attendant care services must:

- (A) Be previously authorized by the services coordinator before services begin;
- (B) Be delivered through the most cost effective method as determined by the services coordinator; and
- (C) Only be provided when the child is present to receive services.

(c) Attendant care services exclude:

(A) Hours that supplant parental responsibilities or other natural supports and services available from the child's family, community, other government or public services, insurance plans, schools, philanthropic organizations, friends, or relatives;

(B) Hours solely to allow a child's primary caregiver to work or attend school;

(C) Hours that exceed what is necessary to support the child;

(D) Support generally provided at the child's age by the child's parent or other family members;

(E) Educational and supportive services provided by schools as part of a free and appropriate education for children and young adults under the Individuals with Disabilities Education Act;

(F) Services provided by the child's family; and

(G) Home schooling.

(d) Attendant care services may not be provided on a 24-hour shift-staffing basis.

(9) RELIEF CARE. Relief care services are provided to a child on a periodic or intermittent basis furnished because of the temporary absence of, or need for relief of, the child's primary caregiver.

(a) Relief care may include both day and overnight services that may be provided in:

(A) The child's family home;

(B) A licensed, certified, or otherwise regulated setting;

(C) A qualified provider's home. If overnight relief care is provided in a qualified provider's home, the services coordinator and the child's parent must document that the home is a safe setting for the child;

(D) A disability-related or therapeutic recreational camp; or

(E) The community, during the provision of ADL, IADL, health related tasks, and other supports identified in the child's ISP.

(b) Relief care services are not authorized for the following:

(A) Solely to allow a child's primary caregiver to attend school or work;

(B) For ongoing services that occur on more than a periodic schedule, such as eight hours a day, five days a week;

(C) For more than 14 consecutive overnight stays in a calendar month;

(D) For more than 10 days per individual plan year when provided at a specialized camp;

(E) For vacation travel and lodging expenses; or

(F) To pay for room and board if provided at a licensed site or specialized camp.

(10) **SPECIALIZED EQUIPMENT AND SUPPLIES.** Specialized equipment and supplies include the purchase of devices, aids, controls, supplies, or appliances that are necessary to enable a child to increase the child's abilities to perform and support ADLs and IADLs or to perceive, control, or communicate with the environment in which the child lives. Specialized equipment and supplies must meet applicable standards of manufacture, design, and installation.

(a) Specialized equipment and supplies include:

(A) Electronic devices to secure assistance in an emergency in the community and other reminders, such as medication minders, alert systems for ADL or IADL supports, or mobile electronic devices. Expenditures for electronic devices are limited to \$500 per plan year. A services coordinator may

request approval for additional expenditures through the Department prior to expenditure.

(B) Assistive technology to provide additional security and replace the need for direct interventions to enable self direction of care and maximize independence, such as motion or sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems.

(i) Expenditures for assistive technology are limited to \$5,000 per plan year. A services coordinator may request approval for additional expenditures through the Department prior to expenditure.

(ii) Any single device or assistance costing more than \$500 must be approved by the Department prior to expenditure.

(C) Assistive devices not covered by other Medicaid programs to assist and enhance a child's independence in performing ADLs or IADLs, such as durable medical equipment, mechanical apparatus, electrical appliances, or information technology devices.

(i) Expenditures for assistive devices are limited to \$5,000 per plan year. A services coordinator may request approval for additional expenditures through the Department prior to expenditure.

(ii) Any single device or assistance costing more than \$500 must be approved by the Department prior to expenditure.

(b) Specialized equipment and supplies may include the cost of a professional consultation, if required, to assess, identify, adapt, or fit specialized equipment. The cost of professional consultation may be included in the purchase price of the equipment.

(c) To be authorized by a services coordinator, specialized equipment and supplies must be:

(A) In addition to any medical equipment and supplies furnished under OHP and private insurance;

(B) Determined necessary to the daily functions of the child;  
and

(C) Directly related to a child's disability.

(d) Specialized equipment and supplies exclude:

(A) Items that are not necessary or of direct medical or remedial benefit to the child;

(B) Specialized equipment and supplies intended to supplant similar items furnished under OHP or private insurance;

(C) Items available through family, community, or other governmental resources;

(D) Items that are considered unsafe for a child;

(E) Toys or outdoor play equipment; and

(F) Equipment and furnishings of general household use.

(e) Funding for specialized equipment and supplies with an expected life of more than one year is one time funding that is not continued in subsequent plan years. Specialized equipment and supplies may only be included in a child's ISP when all other public and private resources have been exhausted.

(f) The services coordinator must secure use of specialized equipment or supplies costing more than \$500 through a written agreement between the Department and the child's parent that specifies the time period the item is to be available to the child and the responsibilities of all parties if the item is lost, damaged, or sold within that time period. The Department may immediately recover any

specialized equipment or supplies purchased with MFC funds that are not used according to the child's ISP or according to the written agreement between the Department and the child's parent.

(11) CHORE SERVICES. Chore services may be provided only in situations where no one else in a child's family home is able of either performing or paying for the services and no other relative, caregiver, landlord, community, volunteer agency, or third-party payer is capable of, or responsible for, providing these services

(a) Chore services include heavy household chores such as --

(A) Washing floors, windows, and walls;

(B) Tacking down loose rugs and tiles; and

(C) Moving heavy items of furniture for safe access and egress.

(b) Chore services may include yard hazard abatement to ensure the outside of a child's family home is safe for the child to traverse and enter and exit the home.

(12) COMMUNITY TRANSPORTATION. Community transportation is provided in order to enable a child to gain access to community services, activities, and resources as specified in the child's ISP. Community transportation excludes:

(a) Transportation provided by a child's family members;

(b) Transportation used for behavioral intervention or calming;

(c) Transportation normally provided by schools;

(d) Transportation normally provided by the child's primary caregiver for a child of similar age without disabilities;

(e) Purchase of any family vehicle;

(f) Vehicle maintenance and repair;

- (g) Reimbursement for out-of-state travel expenses;
- (h) Ambulance services or medical transportation; or
- (i) Transportation services that may be obtained through other means, such as OHP or other public or private resources available to the child.

(13) FAMILY TRAINING. Family training services include the purchase of training, coaching, counseling, and support that increase the abilities of a child's family to care for and maintain the child in the child's family home. Family training services include:

- (a) Instruction about treatment regimens and use of equipment specified in the child's ISP;
- (b) Counseling services that assist the child's family with the stresses of having a child with an intellectual or developmental disability or medical condition.

(A) To be authorized, the counseling services must:

- (i) Be provided by licensed providers, including but not limited to psychologists licensed under ORS 675.030, professionals licensed to practice medicine under ORS 677.100, social workers licensed under ORS 675.530, or counselors licensed under ORS 675.715;
- (ii) Directly relate to the child's intellectual or developmental disability or medical condition and the ability of the child's family to care for the child; and
- (iii) Be short-term.

(B) Counseling services exclude:

- (i) Therapy that may be obtained through OHP or other payment mechanisms;
- (ii) General marriage counseling;

(iii) Therapy to address the psychopathology of the child's family members;

(iv) Counseling that addresses stressors not directly attributed to the child;

(v) Legal consultation;

(vi) Vocational training for the child's family members; and

(vii) Training for families to carry out educational activities in lieu of school.

(c) Registration fees for organized conferences, workshops, and group trainings that offer information, education, training, and materials about the child's medical or health condition.

(A) Conferences, workshops, or group trainings must be prior authorized by the services coordinator, directly relate to the child's intellectual or developmental disability or medical condition, and increase the knowledge and skills of the child's family to care for and maintain the child in the child's family home.

(B) Conference, workshop, or group training costs exclude:

(i) Registration fees in excess of \$500 per family for an individual event;

(ii) Travel, food, and lodging expenses;

(iii) Services otherwise provided under OHP or available through other resources; or

(iv) Costs for individual family members who are employed to care for the child.

(14) SPECIAL DIETS. Special diets do not constitute a full nutritional regime.

(a) In order for a special diet to be authorized --

(A) The foods must be on the approved list developed by the Department;

(B) The special diet must be ordered at least annually by a physician licensed by the Oregon Board of Medical Examiners;

(C) The special diet must be periodically monitored by a dietician or physician; and

(D) The special diet may not be reimbursed through OHP or any other source of public or private funding.

(b) A special diet excludes restaurant and prepared foods, vitamins, and supplements.

(15) TRANSLATION. If the primary language of a child or the child's primary caregiver is not English, translation service is provided to enable the child or the primary caregiver to communicate with providers of MFC services.

(16) DIRECT NURSING SERVICES. If a child's service needs require the presence of an RN or LPN on a routine basis as determined necessary based on the child's assessed needs, direct hourly nursing services may be allocated to ensure medically necessary supports are provided.

(a) Direct nursing services may be provided on a shift staffing basis as necessary.

(b) Direct nursing services must be delivered by a licensed RN or LPN, as determined by the child's service needs and documented in the child's ISP.

(17) The Department may expend funds through contract, purchase order, use of credit card, payment directly to the vendor, or any other legal payment mechanism.

(18) MFC services for a child not on the Hospital Model Waiver are limited to attendant care services only.

(19) All MFC services authorized by the Department must be included in a written ISP in order to be eligible for payment. The ISP must use the most cost effective services for safely meeting a child's needs as determined by a services coordinator.

(20) SERVICE LEVELS. The Department bases the average monthly service level for the MFC services authorized in the ISP on the child's service level as follows:

(a) Level I.

(A) A child who is eligible for level I services must:

(i) Be ventilator-dependent for 20 or more hours per day;

(ii) Have a score on the clinical criteria of 75 or greater;  
and

(iii) Require that the provider or primary caregiver be awake for the full 24 hours.

(B) A child must be ventilator-dependent 24 hours per day for the maximum service budget to be allowed.

(b) Level II.

(A) A child who is eligible for level II services must:

(i) Be ventilator-dependent for 14 to 20 hours per day;

(ii) Have a score on the clinical criteria between 70 and 74; and

(iii) Require the provider or primary caregiver to remain awake for the full 24 hours.

(B) A child must be ventilator-dependent 20 hours per day for the maximum service budget to be allowed.

(c) Level III.

(A) A child who is eligible for level III services must:

- (i) Be ventilator-dependent for 6 to 13 hours per day;
- (ii) Have a score on the clinical criteria between 65 and 69; and
- (iii) Require the provider or primary caregiver to remain awake for the full 24 hours.

(B) A child must be ventilator-dependent 13 hours per day for the maximum service budget to be allowed.

(d) Level IV.

(A) A child who is eligible for level IV services must:

- (i) Be ventilator-dependent for up to 6 hours per day;
- (ii) Have a score on the clinical criteria between 60 and 64; and
- (iii) Require the provider or primary caregiver to remain awake for the full 24 hours.

(B) A child must be ventilator-dependent 6 hours per day for the maximum budget to be allowed.

(e) Level V. A child who is eligible for level V services must:

- (A) Have a score on the clinical criteria between 50 and 59; and
- (B) Require close proximity of the provider or primary caregiver to monitor for the full 24 hours.

(f) Level VI. A child who is eligible for level VI services must:

(A) Have a score on the clinical criteria less than 50;

(B) Meet the eligibility criteria in OAR 411-350-0030; and

(C) Not have been transitioned out of MFC services.

(21) EXCEPTIONS.

(a) Exceptions are only authorized by the Department in the following circumstances:

(A) To prevent a child's hospitalization;

(B) To provide initial teaching of new service needs; or

(C) A significant medical condition or event occurs that prevents or seriously impedes the child's primary caregiver from providing services as documented by a physician.

(b) Exceptions may not exceed 60 consecutive days without MFCU supervisor review and approval.

(22) The Department does not pay for MFC services that are:

(a) Notwithstanding abuse as defined in ORS 419B.005, abusive, aversive, or demeaning;

(b) Experimental;

(c) Illegal, including crimes identified in OAR 407-007-0275;

(d) Determined unsafe for the general public by recognized child and consumer safety agencies;

(e) Not necessary or cost effective;

- (f) Educational services for school-age children, including professional instruction, formal training, and tutoring in communication, socialization, and academic skills;
- (g) Services or activities that the legislative or executive branch of Oregon government has prohibited use of public funds;
- (h) Medical treatments; or
- (i) Services or supplies provided by private health insurance or OHP.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

**411-350-0060 Denial of Services, Amount of Services, or Eligibility**  
*(Renumbered to OAR 411-350-0118)*

**411-350-0070 Scope and Limitations of In-Home Daily Care Services**  
*(Repealed 3/1/2009) Rule text moved to OAR 411-350-0050*

**411-350-0080 Standards for Providers**  
*(Amended 12/28/2013)*

(1) A provider must:

- (a) Be at least 18 years of age;
- (b) Maintain a drug-free work place;
- (c) Provide evidence satisfactory to the Department that demonstrates by background, education, references, skills, and abilities, the provider is capable of safely and adequately providing the services authorized;
- (d) Consent to and pass a background check by the Department as described in OAR 407-007-0200 to 407-007-0370, 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, or as needed if a report of a criminal activity has been received.

(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 homes within the jurisdiction of the qualified entity as defined in OAR 407-007-0210. The Department's Background Check Request Form must be completed by the subject individual to show intent to work at various homes.

(e) Effective July 28, 2009, not have been convicted of any of the disqualifying crimes listed in OAR 407-007-0275;

(f) Not be the child's primary caregiver, parent, stepparent, foster provider, residential services provider, or legal guardian; and

(g) Sign a Medicaid provider agreement and be enrolled as a Medicaid provider prior to delivery of any attendant care services.

(2) Section (1)(e) of this rule does not apply to employees of the child's parent or employees of billing providers who were hired prior to July 28, 2009 that remain in the current position for which the employee was hired.

(3) All providers must self-report any potentially disqualifying condition as described in OAR 407-007-0280 and OAR 407-007-0290. The provider must notify the Department or the Department's designee within 24 hours.

(4) A provider who is providing attendant care services as a nurse must have:

(a) A current Oregon nursing license; and

(b) Be in good standing with appropriate professional associations and boards.

(5) A provider is not an employee of the Department or the state of Oregon and is not eligible for state benefits and immunities, including but not limited to the Public Employees' Retirement System or other state benefit programs.

(6) If the provider or billing provider is an independent contractor during the terms of the contract, the provider or billing provider must maintain in force, at the providers own expense, professional liability insurance with a combined single limit of not less than \$1,000,000 for each claim, incident, or occurrence. Professional liability insurance is to cover damages caused by error, omission, or negligent acts related to the professional services.

(a) The provider or billing provider must provide written evidence of insurance coverage to the Department prior to beginning work.

(b) There must be no cancellation of insurance coverage without 30 days written notice to the Department.

(7) If the provider is an employee of the child's parent, the provider must submit documentation of immigration status required by federal statute to the Department. The Department maintains documentation of immigration status required by federal statute as a service to the parent, who is the employer.

(8) A billing provider that wishes to enroll with the Department must maintain and submit evidence of the following upon initial application or upon the Department's request:

(a) A current, valid, non-restricted Oregon nurses' licenses for each employee who is providing services as a nurse;

(b) A current background check on each employee who provides services in a child's family home that shows the employee has no disqualifying criminal convictions, including crimes as described in OAR 407-007-0275;

(c) Professional liability insurance that meets the requirements of section (6) of this rule; and

(d) Any licensure required of the agency by the state of Oregon or federal law or regulation.

(9) A provider must immediately notify a child's parent and the Department of injury, illness, accidents, or any unusual circumstances that may have a

serious effect on the health, safety, physical, emotional well being, or level of service required by the child for whom services are being provided.

(10) Providers are mandatory reporters and are required to report suspected child abuse to their local Department office or to the police in the manner described in ORS 419B.010.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

**411-350-0090 Prior Authorization for In-Home Daily Care**  
*(Repealed 3/1/2009) Rule text moved to OAR 411-350-0050*

**411-350-0100 Documentation Needs for Medically Fragile Children's Services**  
*(Amended 12/28/2013)*

(1) Original, accurate timesheets of MFC services must be dated and signed by the provider and the child's primary caregiver after the services are provided and maintained and submitted to the Department with any request for payment for services.

(2) Requests for payment for MFC services must:

(a) Include an original copy of the billing form indicating prior authorization for the services;

(b) Be signed by the provider or billing provider, acknowledging agreement with the terms and condition of the billing form and attesting that the hours were delivered as billed; and

(c) Be signed by the child's primary caregiver after the services were delivered, verifying that the services were delivered as billed.

(3) Documentation of provided MFC services must be provided to the services coordinator upon request and maintained in the family home or the place of business of the provider of services. The Department does not pay for services unrelated to a child's disability as outlined in the child's ISP.

(4) A Nursing Care Plan must be developed within seven days of the initiation of MFC services and submitted to the Department for approval when attendant care services are provided by a nurse.

(a) The Nursing Care Plan must be reviewed, updated, and resubmitted to the Department in the following instances:

(A) Every six months;

(B) Within seven working days of a change of the nurse who writes the Nursing Care Plan;

(C) With any request for authorization of an increase in hours of service; or

(D) After any significant change of condition, such as hospital admission or change in health status.

(b) The provider must share the Nursing Care Plan with the parent.

(5) Attendant care services provided by a nurse must be documented and maintained in a format acceptable to the Department, contain information required by the Department, and submitted to the Department upon request.

(6) Delegation, teaching, and assignment of nursing tasks and performance of nursing care must be in accordance with OAR chapter 851.

(7) The Department must be notified by the provider or the child's primary caregiver within one working day of the hospitalization or death of any eligible child.

(8) The Department retains billing forms and timesheets for at least five years from the date of service.

(9) The billing provider must maintain documentation of provided services for at least seven years from the date of service. If a provider is a nurse and does not use a billing provider, the nurse must either maintain documentation of provided services for at least five years or send the documentation to the Department.

(10) Providers or billing providers must furnish requested documentation immediately upon the written request from the Department, the Oregon Department of Justice Medicaid Fraud Unit, Centers for Medicare and Medicaid Services, or their authorized representatives, or within the timeframe specified in the written request. Failure to comply with the request may be considered by the Department as reason to deny or recover payments.

(11) Access to records by the Department inclusive of medical, nursing, or financial records, to include providers and vendors providing goods and services, does not require authorization or release by the child's primary caregiver.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

**411-350-0110 Payment for Medically Fragile Children's Services**  
(Amended 12/28/2013)

(1) Service levels are individually determined by the Department, based on the individual assessed needs of the child.

(2) Effective July 28, 2009, public funds may not be used to support, in whole or in part, a provider in any capacity who has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275.

(3) Section (2) of this rule does not apply to employees of a child's parent or billing provider who were hired prior to July 28, 2009 that remain in the current position for which the employee was hired.

(4) Authorization must be obtained prior to the delivery of any MFC services for the services to be eligible for reimbursement.

(5) Providers must request payment authorization for MFC services provided during an unforeseeable emergency on the first business day following the emergency service. The services coordinator must determine if the service is eligible for payment.

(6) The delivery of authorized MFC services must occur so that any individual employee of the child's parent does not exceed 40 hours per work week. The Department does not authorize services that require the payment of overtime, without prior written authorization by the MFCU Supervisor.

(7) The Department makes payment for MFC services, described in OAR 411-350-0050, after services are delivered as authorized and required documentation is received by the services coordinator.

(8) The Department makes payment to the individual employee of the child's parent on behalf of the parent. The following are ancillary contributions:

(a) The Department pays the employer's share of the Federal Insurance Contributions Act tax (FICA) and withholds the employee's share of FICA as a service to the parent, who is the employer.

(b) The Department covers real and actual costs to the Employment Department in lieu of the parent, who is the employer.

(9) Holidays are paid at the same rate as non-holidays.

(10) Travel time to reach the job site is not reimbursable.

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

(12) Payment by the Department for MFC services is considered full payment for the services rendered under Title XIX or Title XXI. A provider or billing provider may not demand or receive additional payment for MFC services from the child's parent or any other source, under any circumstances.

(13) Medicaid funds are the payer of last resort. The provider or billing provider must bill all third party resources until all third party resources are exhausted.

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

(15) The Department may void without cause prior authorizations that have been issued in the event of any of the following:

- (a) Change in the status of the child, such as hospitalization, improvement in health status, or death of the child;
- (b) Decision of the parent to change providers;
- (c) Inadequate services, inadequate documentation, or failure to perform other expected duties;
- (d) Documentation of a person who is subject to background checks on or after July 28, 2009, as required by administrative rule, has been convicted of any of the disqualifying crimes listed in OAR 407-007-0275; or
- (e) Any situation, as determined by the services coordinator that puts the child's health or safety at risk.

(16) Section (15)(d) of this rule does not apply to employees of parents or billing providers who were hired prior to July 28, 2009 that remain in the current position for which the employee was hired.

(17) Upon submission of the billing form for payment, the provider must comply with:

- (a) All rules in OAR chapter 407 and chapter 411;
- (b) 45 CFR Part 84 that implements Title V, Section 504 of the Rehabilitation Act of 1973;
- (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.

(18) All billings must be for MFC services provided within the provider's licensure.

(19) The provider must submit true and accurate information on the billing form. Use of a billing provider does not replace the provider's responsibility for the truth and accuracy of submitted information.

(20) No person shall submit to the Department:

(a) A false billing form for payment;

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

(c) Any billing form for MFC services that have not been provided.

(21) The Department only makes payment to the enrolled provider who actually performs the MFC services or the provider's enrolled billing provider. Federal regulations prohibit the Department from making payment to collection agencies.

(22) Payments may be denied if any provisions of these rules are not complied with.

(23) The Department recoups all overpayments.

(a) The amount to be recovered:

(A) Is the entire amount determined or agreed to by the Department;

(B) Is not limited to the amount determined by criminal or civil proceedings; and

(C) Includes interest to be charged at allowable state rates.

(b) A request for repayment of the overpayment or notification of recoupment of future payments is delivered to the provider by registered or certified mail or in person.

(c) Payment schedules with the interest may be negotiated at the discretion of the Department.

(d) If recoupment is sought from a child's parent, hearing rights in OAR 411-350-0118 apply.

(24) Payment for services provided to more than one child in the same setting at the same time may not exceed the maximum hourly rate for one child without prior written authorization by the MFCU Supervisor.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

### **411-350-0115 Complaints and Grievances**

*(Amended 12/28/2013)*

(1) COMPLAINTS AND GRIEVANCES. The Department shall address all grievances in accordance with Department written policies, procedures, and rules. Copies of the procedures for resolving grievances shall be maintained on file at the Department. These policies and procedures, at a minimum, shall address:

(a) The child's parent has an opportunity to informally discuss and resolve any complaint or grievance regarding action taken by the Department that is contrary to law, rule, or policy and that does not meet the criteria for an abuse investigation. Choosing an informal resolution does not preclude the parent from pursuing resolution through formal grievance processes.

(b) The Department shall maintain a log of all complaints regarding the provision of MFC services received via phone calls, e-mails, or writing.

(A) At a minimum, the complaint log shall include:

(i) The date the complaint was received;

(ii) The name of the person taking the complaint;

(iii) The nature of the complaint;

(iv) The name of the person making the complaint, if known; and

(v) The disposition of the complaint.

(B) Child welfare and law enforcement reports of abuse or neglect shall be maintained separately from the central complaint and grievance log.

(c) Response to complaints. Department staff response to the complaint must be provided within five working days following receipt of the complaint and must include an investigation of the facts supporting or disproving the complaint. Any agreement to resolve the complaint must be in writing and must be specifically approved by the grievant. The Department shall provide the grievant with a copy of the agreement.

(d) Review. A manager of the Department must review the complaint if the complaint involves Department staff or services, or if the complaint is not or may not be resolved with Department staff. The manager's response to the complaint must be made in writing within 30 days following receipt of the complaint, and include a response to the complaint as described in subsection (1)(c) of this section.

(e) Third-party review when complaints are not resolved by a Department manager. Unless the complainant is a Medicaid recipient who has elected to initiate the hearing process according to OAR 411-350-0118, a complaint involving the provision of service or a service provider may be submitted to the Department for an administrative review.

(A) The grievant must submit to the Department a request for an administrative review within 15 days from the date of the decision by the Department manager.

(B) Upon receipt of a request for an administrative review, the Department's director shall appoint an Administrative Review Committee and name the chairperson. The Administrative Review Committee shall be comprised of two representatives of

the Department. Committee representatives may not have any direct involvement in the provision of services to the grievant or have a conflict of interest in the specific case being grieved.

(C) The Administrative Review Committee must review the complaint and the decision by the Department manager and make a recommendation to the Department's director within 45 days of receipt of the complaint unless the grievant and the Administrative Review Committee mutually agree to an extension.

(D) The Department's director shall consider the report and recommendations of the Administrative Review Committee and make a final decision. The decision must be in writing and issued within 10 days of receipt of the recommendation by the Administrative Review Committee. The written decision must contain the rationale for the decision.

(E) The decision of the Department's director is final. Any further review is pursuant to the provision of ORS 183.484 for judicial review.

(f) Documentation of complaint. Documentation of each complaint and the resolution of the complaint must be filed or noted in the complainant's record.

(2) NOTIFICATION. Upon enrollment and annually thereafter, the Department must inform each child's parent orally and in writing, using language, format, and methods of communication appropriate to the parent's needs and abilities, of the following:

(a) The Department's grievance policy and procedures, including the right to an administrative review and the method to obtain an administrative review; and

(b) The right of a Medicaid recipient to a hearing pursuant to OAR 411-350-0118 and the procedure to request a hearing.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

**411-350-0118 Denial, Termination, Suspension, Reduction, or Eligibility of Services for Individual Medicaid Recipients**

*(Amended 12/28/2013)*

(1) Each time the Department takes an action to deny, terminate, suspend, or reduce a child's access to services covered under Medicaid, the Department shall notify the child's parent of the right to a hearing and the method to request a hearing. The Department shall mail the notice by certified mail, or personally serve the notice to the parent 10 days or more prior to the effective date of the action.

(a) The Department shall use the Notice of Hearing Rights or a comparable Department-approved form. A notice of hearing rights is not required if an action is part of, or fully consistent with, a child's ISP, or the child's parent has agreed with the action by signature to the ISP. The notice of hearing rights shall be given directly to the parent when the ISP is signed.

(b) The child's parent may appeal a denial of a request for additional or different services only if the request has been made in writing and submitted to the address on the notice to expedite the process.

(c) A notice required by this section of this rule must include:

(A) The action the Department intends to take;

(B) The reasons for the intended action;

(C) The specific Oregon Administrative Rules that supports, or the change in federal or state law that requires, the action;

(D) The appealing party's right to request a hearing in accordance with OAR chapter 137, Oregon Attorney General's Model Rules, ORS chapter 183, and 42 CFR Part 431, Subpart E;

(E) A statement that the Department files on the subject of the hearing automatically becoming part of the hearing record upon default for the purpose of making a prima facie case;

(F) A statement that the actions specified in the notice shall take effect by default if the Department representative does not receive a request for hearing from the party within 45 days from the date that the Department mails the notice of action;

(G) In cases of an action based upon a change in law, the circumstances under which a hearing shall be granted; and

(H) An explanation of the circumstances under which MFC services shall be continued if a hearing is requested.

(d) If the child's parent disagrees with the decision or proposed action of the Department to deny, terminate, suspend, or reduce a child's access to services covered under Medicaid, the parent may request a hearing as provided in ORS chapter 183. The request for a hearing must be in writing on Form DHS 443 and signed by the parent. The signed form (DHS 443) must be received by the Department within 45 days from the date of the Department's notice of action.

(e) The child's parent may request an expedited hearing if the parent feels that there is an immediate, serious threat to the child's life or health if the normal timing of the hearing process is followed.

(f) If the child's parent requests a hearing before the effective date of the proposed actions and requests that the existing services be continued, the Department shall continue the services.

(A) The Department shall continue the services until whichever of the following occurs first:

(i) The current authorization expires;

(ii) The administrative law judge issues a proposed order and the Department issues a final order; or

(iii) The child is no longer eligible for Medicaid benefits.

(B) The Department shall notify the child's parent that the Department is continuing the service. The notice shall inform

the parent that, if the hearing is resolved against the child, the Department may recover the cost of any services continued after the effective date of the continuation notice.

(g) The Department may reinstate services if:

(A) The Department takes an action without providing the required notice and the child's parent requests a hearing;

(B) The Department fails to provide the notice in the time required in this rule and the child's parent requests a hearing within 10 days of the mailing of the notice of action; or

(C) The post office returns mail directed to the child's parent but the location of the parent becomes known during the time that the child is still eligible for services.

(h) The Department shall promptly correct the action taken up to the limit of the original authorization, retroactive to the date the action was taken, if the hearing decision is favorable to the child, or the Department decides in the child's favor before the hearing.

(i) The Department representative and the child's parent may have an informal conference without the presence of the administrative law judge to discuss any of the matters listed in OAR 137-003-0575. The informal conference may also be used to:

(A) Provide an opportunity for the Department and the child's parent to settle the matter;

(B) Ensure the child's parent understands the reason for the action that is the subject of the hearing request;

(C) Give the child's parent an opportunity to review the information that is the basis for that action;

(D) Inform the child's parent of the rules that serve as the basis for the contested action;

(E) Give the child's parent and the Department the chance to correct any misunderstanding of the facts;

(F) Determine if the child's parent wishes to have any witness subpoenas issued; and

(G) Give the Department an opportunity to review the Department's action.

(j) The child's parent may, at any time prior to the hearing date, request an additional conference with the Department representative. At the Department representative's discretion, the Department representative may grant an additional conference if the additional conference facilitates the hearing process.

(k) The Department may provide the child's parent the relief sought at any time before the final order is issued.

(l) A child's parent may withdraw a hearing request at any time prior to the issuance of a final order. The withdrawal shall be effective on the date the Department or the Office of Administrative Hearings receives the request for withdrawal. The Department shall issue a final order confirming the withdrawal to the last known address of the parent. The parent may cancel the withdrawal up to 10 working days following the date the final order is issued.

## (2) PROPOSED AND FINAL ORDERS.

(a) In a contested case, the administrative law judge must serve a proposed order on the child and the Department.

(b) If the administrative law judge issues a proposed order that is adverse to the child, the child's parent may file an exception to the proposed order to be considered by the Department. The exceptions must be in writing and must be received by the Department no later than 10 days after service of the proposed order. The child's parent may not submit additional evidence after this period unless the Department grants prior approval.

(c) After receiving the exceptions, if any, the Department may adopt the proposed order as the final order or may prepare a new order. Prior to issuing the final order, the Department may issue an amended proposed order.

(3) The provider or billing provider must submit relevant documentation to the Department within five working days at the request of the Department when a hearing has been requested.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215

### **411-350-0120 Sanctions for Providers of Medically Fragile Children's Services**

*(Amended 12/28/2013)*

(1) Sanctions may be imposed on a provider when any of the following conditions is determined by the Department to have occurred:

(a) The provider has been convicted of any crime that would have resulted in an unacceptable background check upon hiring or issuance of a provider number;

(b) The provider has been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(c) The provider's license has been suspended, revoked, otherwise limited, or surrendered;

(d) The provider has failed to safely provide the MFC services authorized as determined by the child's parent or the services coordinator;

(e) The provider has had a founded report of child abuse or substantiated abuse;

(f) The provider has failed to cooperate with any investigation or grant access to or furnish records or documentation as requested;

(g) The provider has billed excessive or fraudulent charges or has been convicted of fraud;

(h) The provider has made a false statement concerning conviction of crime, founded report of child abuse, or substantiated abuse;

(i) The provider has falsified required documentation;

(j) The provider has been suspended or terminated as a provider by the Department or Oregon Health Authority; or

(k) The provider has not adhered to the provisions of these rules.

(2) The Department may impose the following sanctions on a provider:

(a) Termination from providing MFC services;

(b) Suspension from providing MFC services for a specified length of time or until specified conditions for reinstatement are met and approved by the Department; or

(c) Withholding payments to the provider.

(3) If the Department makes a decision to sanction a provider, the provider must be notified by mail of the intent to sanction.

(a) The provider may appeal a sanction by requesting an administrative review by the Department's director.

(b) For an appeal to be valid, written notice of the appeal must be received by the Department within 45 days of the date the sanction notice was mailed to the provider.

(c) The provider must appeal a sanction separately from any appeal of audit findings and overpayments.

(4) At the discretion of the Department, providers who have previously been terminated or suspended by the Department or the Oregon Health Authority may not be re-enrolled as providers of Medicaid services.

Stat. Auth.: ORS 409.050

Stats. Implemented: ORS 427.005, 427.007, and 430.215