DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 350

MEDICALLY FRAGILE CHILDREN SERVICES

EFFECTIVE JULY 2, 2013

411-350-0010 Purpose
(Amended 3/1/2009)

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 (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. 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 the 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, & 430.215

411-350-0020 Definitions
(Temporary Effective 7/2/2013 - 12/29/2013)

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)" mean those personal, functional activities required by a child for continued well-being that are essential for health and safety.

(3) "Aide" means a nonlicensed caregiver who may or may not be a certified nursing assistant.

(4) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210 (Criminal Records and Abuse Check for Providers).

(5) "Behavior Support Plan (BSP)" means a 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.

(6) "Billing Provider" means an organization that enrolls and contracts with the Department to provide services through an employee and bills the Department for the provider's services.

(7) "Child" means an individual who is less than 18 and applying for or eligible for medically fragile children services.

(8) "Chore Services" mean the services described in OAR 411-350-0050 needed to maintain a clean, sanitary, and safe environment in a child's home. Chore services include heavy household chores such as washing floors, windows, and walls, tacking down loose rugs and tiles, and moving heavy items of furniture for safe access and egress. Chore services may include yard hazard abatement to ensure the outside of the home is safe for the child to traverse and enter and exit the home.

(9) "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.

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

(11) "Community Nursing Services" mean the services described in OAR 411-350-0050 that include nurse delegation and care coordination for a child living in his or her own home. Community nursing services do not

include direct nursing care and are not covered by other Medicaid spending authorities

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

(13) "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 the registered nurse follows all steps of the delegation process as outlined in OAR chapter 851, division 047. Delegation by physicians is also allowed.

(14) "Department" means the Department of Human Services (DHS). The term "Department" is synonymous with "Seniors and People with Disabilities Division (Division)".

(15) "Developmental Disability (DD)" 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.

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

(17) "Environmental Accessibility Adaptations" mean the physical adaptations as described in OAR 411-355-0050 that are necessary to ensure the health, welfare, and safety of a child in the home, or that enable the child to function with greater independence in the home.

(18) "Family Home" means the residence of a child that may, for the purpose of these rules, include a certified foster home.

(19) "Family Training" means training and counseling services for the family of a child that increase the family's capacity to care for, support, and maintain the child in the home as described in OAR 411-300-0150.

(a) Family training includes:

(A) Instruction about treatment regimens and use of equipment specified in the child's Plan of Care;

(B) Information, education, and training about the child's intellectual or developmental disability, medical, or behavioral conditions; and

(C) Counseling for the family to relieve the stress associated with caring for a child with an intellectual or developmental disability.

(b) To determine who may receive family training, family means a unit of two or more persons that include at least one child with an intellectual or developmental disability where the primary caregiver is:

(A) Related to the child by blood, marriage, or legal adoption; or

(B) In a domestic relationship where partners share:

(i) A permanent residence;

(ii) Joint responsibility for the household in general (e.g. child-rearing, maintenance of the residence, basic living expenses); and

(iii) Joint responsibility for supporting the child and the child is related to one of the partners by blood, marriage, or legal adoption.

(20) "Founded Reports" means the Department's Children, Adults, and Families Division or Law Enforcement Authority (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.

(21) "Functional Needs Assessment (FNAT)" means an assessment that documents the level of need, accommodates a child's participation in service planning, and includes --

(a) Completing a comprehensive and holistic assessment;

(b) Surveying physical, mental, and social functioning; and

(c) Identifying risk factors, choices and preferences, and service needs.

(22) "Home and Community-Based Waivered 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.

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

(24) "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.

(25) "In-Home Daily Care (IHDC)" means Medicaid state plan funded essential supportive daily care as described in OAR 411-350-0050 delivered by a qualified provider that enables a child to remain, or return to, the family home.

(26) "Instrumental Activities of Daily Living (IADL)" mean those activities, other than activities of daily living, required to continue independent living.

(27) "Intellectual Disability" has the meaning set forth in OAR 411-320-0020 and described in OAR 411-320-0080.

(28) "Level of Care" means an assessment completed by a services coordinator has determined a child meets institutional level of care. A child meets institutional level of care for hospital level of care for children with intellectual or developmental disabilities if --

(a) A child has a documented medical condition and demonstrates the need for active treatment as assessed by the clinical criteria as defined in OAR 411-350-0020.

(b) A child's medical condition requires the care and treatment of services normally provided in an acute medical hospital.

(29) "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, 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 such information communicated by a person if the communication is privileged under ORS 40.225 to 40.295.

(30) "Medicaid Fair Hearing" means the formal process following an action that would terminate, suspend, reduce, or deny a Medicaid service. This is a formal process required by federal law (42 CFR 431.200-250). A Medicaid Fair Hearing is also known as a contested case hearing.

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

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

(33) "MFC" means "Medically Fragile Children" as defined in this rule.

(34) "Natural Supports" or "Natural Support System" means the resources available from relatives, friends, significant others, neighbors, roommates, and the community. Services provided by natural supports are resources that are not paid for by the Department.

(35) "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.

(36) "Nursing Care Plan" means a plan of care 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 qualified provider or primary caregiver. When a Nursing Care Plan exists, it becomes a part of the Plan of Care.

(37) "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.

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

(39) "Oregon Intervention System (OIS)" means a system of providing training to people who work with designated individuals to intervene physically or non-physically to keep individuals from harming self or others. OIS is based on a positive approach that includes methods of effective evasion, deflection, and escape from holding.

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

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

(42) "Person-Centered Planning" means:

(a) A process, either formal or informal, for gathering and organizing information that helps:

(A) Determine and describe choices about personal goals, activities, and lifestyle preferences;

(B) Design strategies and networks of support to achieve goals and a preferred lifestyle using 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 a child's needs and preferences.

(43) "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.

(44) "Plan of Care" means the written details of the supports, activities, and resources required for a child to achieve personal outcomes. 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 a Plan of Care. The Plan of Care is developed at minimum annually to reflect decisions and agreements made during a person-centered process of planning and information gathering. The Plan of Care includes a Nursing Care Plan when one exists. The Plan of Care reflects whether services are provided through a waiver, state plan, or through a child's natural supports.

(45) "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.

(46) "Primary Caregiver" means the parent or foster provider that provides the direct care of the child at the times that a paid provider is not available.

(47) "Provider or Performing Provider" means a person who meets the requirements of OAR 411-350-0080 that is qualified to receive payment from the Department for in-home daily care. Providers work directly with medically fragile children. Providers may be employees of billing providers, employees of a child's parent, or independent contractors.

(48) "Respite" means intermittent services as described in OAR 411-300-0150 provided on a periodic basis, but not more than 14 consecutive days, for the relief of, or due to the temporary absence of a child's primary caregiver.

(49) "Service Budget" means the monthly dollar amount allotted for the care of the child based on the clinical criteria. The service budget consists of in-home daily care and, if the child is on a waiver, waivered services. Service budgets increase or decrease in direct relationship to the increasing or decreasing clinical criteria score.

(50) "Services Coordinator" means an employee of the Department who ensures a child's eligibility for medically fragile children services and provides assessment, case management, service implementation, and evaluation of the effectiveness of the services.

(51) "Specialized Diet" means specially prepared or particular types of food needed to sustain a child in the family home as described in OAR 411-350-0050.

(52) "Specialized Equipment and Supplies" mean devices, aids, controls, supplies, or appliances as described in OAR 411-300-0150 that meet applicable standards of manufacture, design, and installation that enable children to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. Specialized equipment and supplies do not include items not of direct benefit to a child.

(53) "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.

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

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

(56) "Transportation" means services as described in OAR 411-300-0150 that allow a child to gain access to community services, activities, and resources that are not medical in nature.

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

(58) "Waivered Services" mean a menu of disability related services and supplies, beyond in-home daily 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, & 430.215

411-350-0030 Eligibility
(Temporary Effective 7/2/2013 - 12/29/2013)

(1) ELIGIBILITY. 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) 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;

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

(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 primary caregiver demonstrating the willingness, skills, and ability to provide the direct care, not paid for in the plan of care, as determined by the service coordinator within the limitations of 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, residential facility, or other institution;

(b) Does not require waivered 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. The Department may place a child eligible for MFC services on a wait list, based on the date of referral, if the allowable numbers of children on the Hospital Model Waiver are already being served. State plan services are available for a child with Medicaid services in place.

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

411-350-0040 Plan of Care
(Temporary Effective 7/2/2013 - 12/29/2013)

(1) To develop the plan of care, the service coordinator must complete an FNAT 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, or when appropriate, others interested individuals. The assessment must identify:

(a) The services for which the child is currently eligible;

(b) The services currently being provided; and

(c) All available family, community, 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 parent and any other person at the parent's request, a written Plan of Care that identifies:

(a) The service needs of the child and the child's family;

(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 some or all of the child's service needs.

(3) The service coordinator must prepare a Plan of Care that includes:

(a) A description of the supports required, including the reason the support is necessary. For an initial or annual Plan of Care that is authorized after July 1, 2013, the description must be consistent with the FNAT;

(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 waivered or state plan services, state general funds, or natural supports;

(c) The maximum hours of authorized provider services;

(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;

(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 may not be authorized when an LPN can safely perform the duties.

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

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

(i) The child's Nursing Care Plan, when one exists.

(4) The parent must review the Plan of Care prior to implementation.

(5) The parent and the services coordinator must sign the Plan of Care and a copy must be provided to the parent.

(6) The services coordinator must reflect significant changes in the needs of the child in the Plan of Care, as they occur, and provide a copy of the revised Plan of Care to the parent.

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

411-350-0050 Scope and Limitations of MFC Services
(Temporary Effective 7/2/2013 - 12/29/2013)

(1) MFC services are intended to support, not supplant, the natural supports supplied by a primary caregiver. Regardless of other services

available, a primary caregiver must provide a minimum of 40 hours per week of in home daily care for the child. MFC services are not available to replace services provided by the primary caregiver or to replace other governmental or community services.

(2) For an initial or annual Plan of Care that is authorized on or after July 1, 2013, medically fragile children services may include a combination of the following waivered and other Medicaid services based upon the needs of a child as determined by the services coordinator and as consistent with the child's Plan of Care:

(a) Community First Choice State Plan services:

(A) Specialized consultation including behavior consultation as described in section (3) of this rule;

(B) Community nursing services as described in section (4) of this rule;

(C) Environmental accessibility adaptations as described in section (5) of this rule;

(D) In-home daily care as described in section (6) of this rule;

(E) Respite as described in section (7) of this rule;

(F) Specialized equipment and supplies as described in section (8) of this rule;

(G) Chore services as described in section (9) of this rule; and

(H) Transportation as described in section (10) of this rule.

(b) Waivered services:

(A) Family training as described in section (11) of this rule;

(B) Specialized diets as described in section (12) of this rule; and

(C) Translation as described in section (13) of this rule.

(3) SPECIALIZED CONSULTATION – BEHAVIOR CONSULTATION. Behavior consultation is only authorized to support a primary caregiver in their caregiving role. Behavior consultation is only authorized, as needed, to respond to specific problems identified by a primary caregiver or services coordinator. Behavior consultants must:

(a) Work with the primary caregiver to identify:

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

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

(C) The unique characteristics of the 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 primary caregiver and 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) Positive, preventive interventions must be emphasized.

(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 family.

(d) Develop emergency and crisis procedures to be used to keep the child, primary caregiver, and provider safe. When interventions in the behavior of the child are necessary, positive, preventative, non-aversive interventions that conform to OIS must be utilized.

(e) Develop a written Behavior Support Plan that includes the following:

(A) Use of clear, concrete language that is understandable to the primary caregiver and provider; and

(B) Describes the assessment, strategies, and procedures to be used.

(f) Teach the provider and primary caregiver the strategies and procedures to be used.

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

(4) COMMUNITY NURSING SERVICES.

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

(b) Medication reviews;

(c) Collateral contact with the services coordinator regarding the child's community health status to assist in monitoring safety and well-being and to address needed changes to the person-centered Plan of Care; and

(d) Delegation of nursing tasks to a provider and primary caregiver so that caregivers may safely perform health related tasks.

(5) ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS. Environmental accessibility adaptations are physical adaptations to a family home that are necessary to ensure the health, welfare, and safety of the child in the family home due to the child's 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 detectors, 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 (lift or interior alterations such as seats, head, and leg rests; and 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 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 family home; and

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

(c) Environmental modifications 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 modifications must be tied to supporting activities of daily living, instrumental activities of daily living, and health-related tasks as identified in the Plan of Care.

(e) Modifications over $500 must be completed by a state licensed contractor. Any modification requiring a permit must be inspected and be certified as in compliance with local codes by local inspectors and filed in provider file prior to payment. Environmental modifications must be made within the existing square footage of the family home, except for external ramps, and cannot add to the square footage of the building. Payment to the contractor is to be withheld until the work meets specifications.

(f) 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.

(6) IN-HOME DAILY CARE. In-home daily 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 in-home daily care must support the child to live as independently as appropriate for the child's age and must be based on the identified needs of the child, supporting the family in a primary caregiving role. Primary caregivers are expected to be present or immediately available during the provision of in-home daily care.

(a) In-home daily 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 home and community;

(H) Assisting the child with appropriate leisure activities to enhance development in the 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 family to health related appointments.

(b) In-home daily 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) In-home daily care services exclude:

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

(B) Hours to allow a primary caregiver to work or attend school;

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

(D) 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;

(E) Services provided by the family; and

(F) Home schooling.

(d) In-home daily care services may not be provided on a 24-hour shift-staffing basis. The child's primary caregiver is expected to provide at least 40 hours of care each week and supervise the child each day with the exception of overnight respite. The 40 hours of care and supervision may not include hours when the child's primary caregiver is sleeping.

(7) RESPITE. Respite 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 primary caregiver.

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

(A) The family home;

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

(C) A qualified provider’s home. If overnight respite 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; or

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

(b) The services coordinator does not authorize respite services:

(A) To allow primary caregivers to attend school or work;

(B) That are ongoing and occur on more than a periodic schedule, such as eight hours a day, five days a week;

(C) On 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.

(8) 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 activities of daily living, or to perceive, control, or communicate with the environment in which the child lives.

(a) Electronic devices to secure assistance in an emergency in the community and other reminders such as medication minders and alert systems for ADL/IADL supports, or mobile electronic devices. Expenditures for electronic devices of more than $500 in a plan year require Department approval.

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

(A) Limit of $5000 per year without Department approval.

(B) Any single device or assistance costing more than $500 must be approved by the Department.

(c) Assistive devices. Examples include durable medical equipment, mechanical apparatus, electrical appliance or information technology device to assist and enhance an individual's independence in performing ADL/IADLs, not covered by other Medicaid programs. Limit of $5000 per year without Department approval. Any single device or assistance costing more than $500 must be approved by the department.

(d) The purchase of 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.

(e) To be authorized by the services coordinator, specialized equipment and supplies must be --

(A) In addition to any medical equipment and supplies furnished under the Oregon Health Plan and private insurance;

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

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

(f) 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 the Oregon Health Plan 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.

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

(h) The services coordinator must secure use of equipment or furnishings 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. Any equipment or supplies purchased with MFC funds that are not used according to the child's annual Plan of Care, or according to the written agreement between the Department and the child's parent, may be immediately recovered.

(9) CHORE SERVICES. Chore services may be provided only in situations where no one else in the household is capable 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

(10) TRANSPORTATION. Non-medical transportation is provided in order to enable a child to gain access to community services, activities, and resources as specified in the child's Plan of Care. Non-medical transportation excludes:

(a) Transportation provided by family members;

(b) Transportation used for behavioral intervention or calming;

(c) Transportation normally provided by schools and by the primary caregiver for children of similar age without disabilities;

(d) Purchase of any family vehicle;

(e) Vehicle maintenance and repair;

(f) Reimbursement for out-of-state travel expenses;

(g) Ambulance services; or

(h) Transportation services that may be obtained through other means such as the Oregon Health Plan or other public or private resources available to the child.

(11) 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 family home. Family training services include:

(a) Counseling services that assist the family with the stresses of having a child with an intellectual or developmental disability.

(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 and the ability of the family to care for the child; and

(iii) Be short-term.

(B) Counseling services are excluded for:

(i) Therapy that could be obtained through the Oregon Health Plan or other payment mechanisms;

(ii) General marriage counseling;

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

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

(v) Legal consultation;

(vi) Vocational training for family members; and

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

(b) Registration fees for organized conferences, workshops, and group trainings that offer information, education, training, and materials about the child’s intellectual or developmental disability, medical, or health conditions.

(A) Conferences, workshops, or group trainings must be prior authorized by the services coordinator and include those that:

(i) Directly relate to the child's intellectual or developmental disability; and

(ii) Increase the knowledge and skills of the child's family to care for and maintain the child in the 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 the Oregon Health Plan or available through other resources; or

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

(12) SPECIALIZED DIETS. Specialized diets do not constitute a full nutritional regime.

(a) In order for a specialized diet to be authorized:

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

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

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

(D) The specialized diet may not be reimbursed through the Oregon Health Plan or any other source of public and private funding.

(b) Restaurant and prepared foods, vitamins, and supplements are specifically excluded from a specialized diet.

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

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

(15) MFC services for a child not on the Hospital Model Waiver are limited to IHDC services only.

(16) All MFC services authorized by the Department must be included in a written Plan of Care in order to be eligible for payment.

(17) The Plan of Care must use the most cost effective services for safely meeting the child's needs as determined by the services coordinator.

(18) SERVICE LEVELS. The Department must base the average monthly service budget for the MFC services authorized in the Plan of Care 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 six 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 six 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 other eligibility criteria in OAR 411-350-0030; and

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

(19) EXCEPTIONS. Exceptions, not to exceed 60 consecutive days without MFCU Supervisor review and approval, are only authorized by the Department in the following circumstances:

(a) To prevent the child's hospitalization.

(b) To provide initial teaching of new care needs.

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

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

(21) 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.

(22) The Department shall 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, & 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 7/1/2010)

(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 Division that demonstrates by background, education, references, skills, and abilities, the provider is capable of safely and adequately providing the IHDC services authorized.

(d) Consent to and pass a criminal records 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) The Department shall perform criminal records rechecks biannually, or as needed, if a report of a criminal activity has been received.

(B) PORTABILITY OF CRIMINAL RECORDS CHECK APPROVAL. Any person meeting the definition of subject individual as defined in OAR 407-007-0200 to 407-007-0370 may be approved for one position to work in multiple homes within the jurisdiction of the qualified entity as defined in OAR 407-007-0200 to 407-007-0370. 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 a parent, step parent, foster provider, or legal guardian of the child.

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

(2) Section (1)(e) of this rule does not apply to employees of parents or employees of billing providers who were hired prior to July 28, 2009 and 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 its designee within 24 hours.

(4) A provider who is providing IHDC 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, 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 Division prior to beginning work.

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

(7) If the provider is an employee of the parent, the provider must submit to the Division documentation of immigration status required by federal statute. The Division shall maintain 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 Division must maintain and submit evidence upon initial application and upon request by the Division of the following:

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

(b) Current criminal records checks on each employee who provides services in a 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 the parent and the Division 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, & 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 MFC Services
(Amended 3/1/2009)

(1) Original, accurate timesheets of MFC services, dated and signed by the provider after the services are provided, must be maintained and submitted to SPD 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 upon request with the terms and condition of the billing form and attesting that the hours were delivered as billed; and

(c) Be signed by the 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 service coordinator upon request and maintained in the family home or the place of business of the provider of services. SPD shall not pay for services unrelated to the child's disability as outlined in the plan of care.

(4) A nursing care plan must be developed within seven days of the initiation of MFC services and submitted to SPD for approval when IHDC services are provided by a nurse.

(a) The nursing care plan must be reviewed, updated, and resubmitted to SPD in the following instances:

(A) Every six months;

(B) Within seven working days of a change of the registered 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. Examples of significant changes of condition include, but are not limited to, hospital admission or change in health status.

(b) The provider must share the nursing care plan with the parent.

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

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

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

(8) SPD shall retain 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 SPD.

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

(11) Access to records by DHS inclusive of medical, nursing, or financial records, to include individuals providing care and vendors providing goods and services, does not require authorization or release by the primary caregiver.

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

411-350-0110 Payment for MFC Services
(Amended 7/1/2010)

(1) Services budgets shall be individually negotiated by the Division, based on the individual 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 parent or billing provider who were hired prior to July 28, 2009 and 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 those 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 shall determine if the service is eligible for payment.

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

(7) The Division shall make 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 Division shall make payment to the individual employee of the parent on behalf of the parent. The following shall be ancillary contributions:

> (a) The Division shall pay the employer's share of the Federal Insurance Contributions Act tax (FICA) and withhold the employee's share of FICA as a service to the parent as the provider's employer.
>
> (b) The Division shall cover real and actual costs to the Employment Department, in lieu of the parent as the provider's 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 Division within six months of the delivery of MFC services.

(12) Payment by the Division for MFC services is considered full payment for the services rendered under Title XIX or Title XXI. Under no circumstances may the provider or billing provider demand or receive additional payment for these services from the parent or any other source.

(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 Division 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 Division 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. Examples include but are not limited to 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 criminal records checks on or after July 28, 2009, as required by administrative rule, and who 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 and 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 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 Division:

(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 Division shall only make payment to the enrolled provider who actually performs the MFC services or the provider's enrolled billing provider. Federal regulations prohibit the Division from making payment to collection agencies.

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

(23) The Division shall recoup all overpayments. The amount to be recovered:

(a) Is the entire amount determined or agreed to by the Division;

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

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

(24) The Division shall deliver to the provider, by registered or certified mail, or in person, a request for repayment of the overpayment or notification of recoupment of future payments.

(25) Payment schedules with the interest may be negotiated at the discretion of the Division.

(26) If recoupment is sought from a parent whose child received MFC services, hearing rights in OAR 411-350-0118 apply.

(27) Payment for services provided to more than one child in the same setting at the same time shall 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, & 430.215

411-350-0115 Complaints and Grievances
(Adopted 3/1/2009)

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

(a) Informal resolution. The parent of a child has an opportunity to informally discuss and resolve any complaint or grievance regarding action taken by SPD 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) Receipt of complaints. SPD 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 individual taking the complaint;

(iii) The nature of the complaint;

(iv) The name of the individual 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. SPD staff response to the complaint must be provided within five working days following receipt of the complaint and must include:

(A) An investigation of the facts supporting or disproving the complaint; and

(B) Any agreement to resolve the complaint must be in writing and must be specifically approved by the grievant. SPD shall provide the grievant with a copy of the agreement.

(d) Review. A manager of SPD must review the complaint if the complaint involves SPD staff or services, or if the complaint is not or cannot be resolved with SPD staff. SPD manager 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 section (1)(c) of this rule.

(e) Third-party review when complaints are not resolved by the SPD manager. Unless the grievant 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 SPD for an administrative review.

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

(B) Upon receipt of a request for an administrative review, the SPD Assistant Director shall appoint an Administrative Review Committee and name the chairperson. The Administrative Review Committee shall be comprised of two representatives of SPD. Committee representatives must 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 SPD manager and make a recommendation to the SPD Assistant Director within 45 days of receipt of the complaint unless the grievant and the Administrative Review Committee mutually agree to an extension.

(D) The SPD Assistant 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 SPD Assistant 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 its resolution must be filed or noted in the grievant's record.

(2) NOTIFICATION. Upon enrollment and annually thereafter, SPD 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) SPD 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, & 430.215

411-350-0118 Denial, Termination, Suspension, Reduction, or Eligibility of Services for Individual Medicaid Recipients
(Amended 3/1/2009)

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

(a) SPD shall use, Notice of Hearing Rights, or a comparable SPD-approved form for such notification. This notification requirement does not apply if an action is part of, or fully consistent with, the plan of care, or the child's parent has agreed with the action by signature to the plan of care. The notice shall be given directly to the parent when the plan of care is signed.

(b) The 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 section (1) of this rule must include:

(A) The action SPD 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 SPD 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 DHS representative does not receive a request for hearing from the party within 45 days from the date that SPD 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 MICP services shall be continued if a hearing is requested.

(d) If the parent disagrees with the decision or proposed action of SPD 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 DHS within 45 days from the date of SPD notice of denial.

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

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

(A) DHS must 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 DHS issues a final order; or

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

(B) DHS must notify the child's parent that DHS is continuing the service. The notice must inform the parent that, if the hearing is resolved against the child, DHS may recover the cost of any services continued after the effective date of the continuation notice.

(g) DHS may reinstate services if:

(A) DHS takes an action without providing the required notice and the parent requests a hearing;

(B) DHS fails to provide the notice in the time required in this rule and the 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 parent, but the location of the parent becomes known during the time that the child is still eligible for services.

(h) DHS must 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 DHS decides in the child's favor before the hearing.

(i) The DHS representative and the 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 DHS and the 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 parent an opportunity to review the information that is the basis for that action;

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

(E) Give the parent and DHS the chance to correct any misunderstanding of the facts;

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

(G) Give DHS an opportunity to review its action.

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

(k) DHS may provide the parent the relief sought at any time before the final order is issued.

(l) A 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 DHS or the Office of Administrative Hearings receives it. DHS must issue a final order confirming the withdrawal to the last known address of the child's parent. The child's 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 DHS.

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

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

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

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

411-350-0120 Sanctions for MFC Providers
(Amended 7/1/2010)

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

(a) The provider has been convicted of any crime that would have resulted in an unacceptable criminal records 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 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, as requested, records or documentation;

(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 another division within the Department; or

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

(2) The Division 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 Division; or

(c) Payments to the provider may be withheld.

(3) If the Division 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 Assistant Director of the Division.

(b) For an appeal to be valid, written notice of the appeal must be received by the Division 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 Division, providers who have previously been terminated or suspended by any division within the Department may not be re-enrolled as providers of Medicaid services.

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