DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
OREGON ADMINISTRATIVE RULES

CHAPTER 411
DIVISION 350

MEDICALLY FRAGILE CHILDREN'S SERVICES

EFFECTIVE AUGUST 20, 2014

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
(Temporary Effective 08/20/2014 to 02/16/2015)

Unless the context indicates otherwise, the following definitions and the definitions in OAR 411-317-0000 apply to the rules in OAR chapter 411, division 350:

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

(2) "ADL" means "activities of daily living" ADL are personal everyday activities such as eating, using the restroom, grooming, dressing, bathing, and transferring.

(3) "Administrator Review" means the Director of the Department reviews a decision upon request, including the documentation related to the decision, and issues a determination.

(4) "Aide" means a non-licensed caregiver who may, or may not, be a certified nursing assistant.

(5) "Assistive Devices" mean the devices, aids, controls, supplies, or appliances described in OAR 411-350-0050 that are necessary to enable a child to increase the ability of the child to perform ADL and IADLs or to perceive, control, or communicate with the environment in which the child lives.

(6) "Assistive Technology" means the devices, aids, controls, supplies, or appliances described in OAR 411-350-0050 that are purchased to provide additional security for a child and replace the need for direct interventions to enable self-direction of care and maximize independence of the child.

(7) "Attendant Care" means assistance with ADL, IADL, and health-related tasks through cueing, monitoring, reassurance, redirection, set-up, hands-on, standby assistance, and reminding as described in OAR 411-350-0050.

(8) "Background Check" means a criminal records check and abuse check as defined in OAR 407-007-0210.

(9) "Behavior Consultant" means a contractor with specialized skills who meets the requirements of OAR 411-350-0080 and provides the services described in OAR 411-350-0050.

(10) "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 the challenging behaviors of a child to become unnecessary and to change the behavior of a provider, adjust environment, and teach new skills.

(11) "Behavior Support Services" mean the services consistent with positive behavioral theory and practice that are provided to assist with behavioral challenges due to the intellectual or developmental disability of a child that prevents the child from accomplishing ADL, IADL, health-related tasks, and cognitive supports to mitigate behavior. Behavior support services are provided in the home or community.

(12) "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.

(13) "CDDP" means "Community Developmental Disability Program" as defined in OAR 411-320-0020.

(14) "Child" means an individual who is less than 18 years of age applying for, or eligible for, medically fragile children's services.

(15) "Chore Services" mean the services described in OAR 411-350-0050 that are needed to restore a hazardous or unsanitary situation in a family home to a clean, sanitary, and safe environment.

(16) "Clinical Criteria" means the criteria used by the Department to evaluate the intensity of the challenges and care needs of medically fragile children.

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

(18) "Community Nursing Services" mean the nursing services described in OAR 411-350-0050 that focus on the chronic and ongoing health and

safety needs of a child living in the family home. Community nursing services include an assessment, monitoring, delegation, training, and coordination of services. Community nursing services are provided according to the rules in OAR chapter 411, division 048 and the Oregon State Board of Nursing rules in OAR chapter 851.

(19) "Community Transportation" means the services described in OAR 411-350-0050 that enable a child to gain access to community-based state plan and waiver services, activities and resources. Community transportation is provided in the area surrounding the family home that is commonly used by people in the same area to obtain ordinary goods and services. The area is not determined by the social or recreational groups or activities of a child.

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

(21) "Cost Effective" means being responsible and accountable with Department resources by offering less costly alternatives when providing choices that adequately meet the support needs of a child. Less costly alternatives include other programs available from the Department, the utilization of assistive devices, natural supports, environmental modifications, and alternative resources. Less costly alternatives may include resources not paid for by the Department.

(22) "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.

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

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

(25) "Director" means the Director of the Department Human Services, Office of Developmental Disability Services, or the designee of the Director.

(26) "Employer" means, for the purpose of obtaining medically fragile children's services through an independent provider as described in these rules, the parent or a person selected by the parent to act on the behalf of the parent to provide the employer responsibilities described in OAR 411-350-0075.

(27) "Environmental Modifications" 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 family home, or that are necessary to enable a child to function with greater independence around the family home.

(28) "Environmental Safety Modifications" mean the physical adaptations described in OAR 411-350-0050 that are made to the exterior of a family home as identified in the ISP for a child to ensure the health, welfare, and safety of the child or to enable the child to function with greater independence around the family home.

(29) "Exit" means termination or discontinuance of medically fragile children's services.

(30) "Expenditure Guidelines" mean the guidelines that describe allowable uses for Medicaid funds. The Department incorporates the expenditure guidelines into these rules by this reference. The expenditure guidelines are maintained by the Department at: http://www.oregon.gov/dhs/dd/. Printed copies of the expenditure guidelines may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, Oregon 97301.

(31) "Family Home" means the primary residence for a child 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.

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

(33) "Founded Report" means the determination by the Department or Law Enforcement Authority (LEA), 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.

(34) "Functional Needs Assessment":

(a) Means the comprehensive assessment or reassessment that:

(A) Documents physical, mental, and social functioning;

(B) Identifies risk factors, choices and preferences, service and support needs, strengths, and goals; and

(C) Determines the service level.

(b) The functional needs assessment for a child is known as the Child Needs Assessment (CNA). The Department incorporates Version B of the CNA dated July 1, 2014 into these rules by this reference. The CNA is maintained by the Department at: www.dhs.state.or.us/spd/tools/dd/cm/CNA_Child_In-home.xls. Printed copies of a blank CNA may be obtained by calling (503) 945-6398 or writing the Department of Human Services, Developmental Disabilities, ATTN: Rules Coordinator, 500 Summer Street NE, E-48, Salem, OR 97301.

(35) "General Business Provider" means an organization or entity selected by a parent and paid with MFC funds that:

(a) Is primarily in business to provide the service chosen by the parent to the general public;

(b) Provides services for the child through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the person who actually provides support for the child.

(36) "Hearing" means "hearing" as defined in OAR 411-318-0005.

(37) "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.

(38) "IADL" means "instrumental activities of daily living". IADL include activities other than ADL required to enable a child to remain in the family home such as:

(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) Participating in the community.

(39) "Independent Provider" means a person selected by a parent and paid with MFC funds to directly provide services to a child.

(40) "Individual-Directed Goods and Services" mean the services, equipment, or supplies described in OAR 411-350-0050, not otherwise provided through other waiver or state plan services, that address an identified need in an ISP. Individual-directed goods and services may include services, equipment, or supplies that improve and maintain the full membership of a child in the community.

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

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

(43) "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.

(44) "Mandatory Reporter" means any public or private official as defined in OAR 407-045-0260 who comes in contact with a child with or without an intellectual or developmental disability and has reasonable cause to believe the child has suffered abuse, or comes in contact with any person whom the public or private official has reasonable cause to believe abused a child, regardless of whether or not the knowledge of the abuse was gained in the official capacity of the public or private official. Nothing contained in ORS 40.225 to 40.295 affects the duty to report imposed by this definition, except that a psychiatrist, psychologist, clergy, attorney, or guardian ad litem appointed under ORS 419B.231 is not required to report if the communication is privileged under ORS 40.225 to 40.295.

(45) "MFC" means "medically fragile children". Medically fragile children 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.

(46) "MFCU" means the "medically fragile children's unit". The MFCU is the program for medically fragile children's services administered by the Department.

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

(48) "Nursing Service Plan" means the plan that is developed by a registered nurse based on an initial nursing assessment, reassessment, or an update made to a nursing assessment as the result of a monitoring visit.

> (a) The Nursing Service Plan is specific to a child and identifies the diagnoses and health needs of the child and any service coordination, teaching, or delegation activities.

(b) The Nursing Service Plan is separate from the ISP and any service plans developed by other health professionals.

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

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

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

(52) "OSIPM" means "Oregon Supplemental Income Program-Medical" as described in OAR 461-001-0030. OSIPM is Oregon Medicaid insurance coverage for individuals who meet the eligibility criteria described in OAR chapter 461.

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

(54) "Person-Centered Planning":

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

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

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

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

(55) "Personal Support Worker" means "personal support worker" as defined in OAR 411-375-0010.

(56) "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 abusive or demeaning interventions are never used; and

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

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

(58) "Private Duty Nursing" 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 family home.

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

(60) "Provider" means a person, organization, or business selected by a parent and paid with MFC funds to provide support to a child according to the ISP for the child.

(61) "Provider Organization" means an entity selected by a parent and paid with MFC funds that:

(a) Is primarily in business to provide supports for children with intellectual or developmental disabilities;

(b) Provides supports for a child through employees, contractors, or volunteers; and

(c) Receives compensation to recruit, supervise, and pay the person who actually provides support for the child.

(62) "Relief Care" means the intermittent services described in OAR 411-350-0050 that are provided on a periodic basis for the relief of, or due to the temporary absence of, a primary caregiver.

(63) "Service Level" means the amount of attendant care, hourly relief care, or skills training services determined necessary by a functional needs assessment and made available to meet the identified support needs of a child.

(64) "Services Coordinator" means an employee of a CDDP, the Department, or other agency that contracts with the county or the Department who provides case management services including, but not limited to, planning, procuring, coordinating, and monitoring services. A services coordinator acts as a proponent for children with intellectual or developmental disabilities and their families and is the person-centered plan coordinator for the child as defined in the Community First Choice state plan amendment.

(65) "Skills Training" means the activities described in OAR 411-350-0050 that are intended to maximize the independence of a child through training, coaching, and prompting the child to accomplish ADL, IADL, and health-related skills.

(66) "Social Benefit" means the service or financial assistance provided to a family solely intended to assist a child to function in society on a level comparable to that of a child who does not have an intellectual or developmental disability. Social benefits are pre-authorized by a services coordinator and provided according to the description and limits written in an ISP.

(a) Social benefits may not:

(A) Duplicate benefits and services otherwise available to a child regardless of intellectual or developmental disability;

(B) Replace normal parental responsibilities for the services, education, recreation, and general supervision of a child;

(C) Provide financial assistance with food, clothing, shelter, and laundry needs common to a child with or without a disability; or

(D) Replace other governmental or community services available to a child.

(b) Assistance provided as a social benefit is reimbursement for an expense previously authorized in an ISP or prior payment in anticipation of an expense authorized in a previously authorized ISP.

(c) Assistance provided as a social benefit may not exceed the actual cost of the support required by a child to be supported in the family home.

(67) "Special Diet" means the specially prepared food or particular types of food described in OAR 411-350-0050 that are specific to the medical condition or diagnosis of a child and in support of an evidence-based treatment regimen.

(68) "Specialized Medical Supplies" mean the medical and ancillary supplies described in OAR 411-350-0050 such as:

(a) Necessary medical supplies specified in an ISP that are not available under the state plan;

(b) Ancillary supplies necessary to the proper functioning of items necessary for life support or to address physical conditions; and

(c) Supplies necessary for the continued operation of augmentative communication devices or systems.

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

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

(71) "Support" means the assistance that a child and a family requires, solely because of the effects of an intellectual or developmental disability or medical condition on the child, to maintain or increase the age-appropriate

independence of the child, achieve age-appropriate community presence and participation of the child, and to maintain the child in the family home. Support is subject to change with time and circumstances.

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

(73) "Transition Costs" mean the expenses described in OAR 411-350-0050 required for a child to make the transition to the family home from a nursing facility, acute care hospital, or intermediate care facility for individuals with intellectual or developmental disabilities.

(74) "Unacceptable Background Check" means a check that produces information related to the background of a person that precludes the person from being an independent provider for one or more of the following reasons:

(a) The person applying to be an independent provider has been disqualified under OAR 407-007-0275;

(b) The person was enrolled as an independent provider for the first time, or after any break in enrollment, after July 28, 2009 and has been disqualified under OAR 407-007-0275; or

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

(75) "Vehicle Modifications" mean the adaptations or alterations described in OAR 411-350-0050 that are made to the vehicle that is the primary means of transportation for a child in order to accommodate the service needs of the child.

(76) "Waiver Services" mean the menu of disability related services and supplies that are specifically identified by the MFC waiver.

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

411-350-0030 Eligibility
(Temporary Effective 08/20/2014 to 02/16/2015)

(1) ELIGIBILITY.

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

(A) Be under the age of 18;

(B) Be an Oregon resident who meets the citizenship and alien status requirements of OAR 461-120-0110;

(C) Be receiving Medicaid Title XIX benefits under OSIPM;

(D) Meet the level of care as defined in OAR 411-350-0020;

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

(F) Reside in the family home; and

(G) Be safely served in the family home. This includes, but is not limited to, a qualified primary caregiver demonstrating the willingness, skills, and ability to provide direct care as outlined in an ISP in a cost effective manner, as determined by a services coordinator within the limitations of OAR 411-350-0050, and participate in planning, monitoring and evaluation of the MFC services provided.

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

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

(a) Resides in a medical hospital, psychiatric hospital, school, sub-acute facility, nursing facility, intermediate care facility for individuals with intellectual or developmental disabilities, residential facility, or other 24-hour residential program. A child that resides in a foster home is eligible for only private duty nursing as described in OAR 411-350-0050;

(b) Does not require waiver services or Community First Choice state plan services as evidenced by a functional needs assessment;

(c) Has sufficient family, government, or community resources available to provide for his or her care; or

(d) Is not safely served in the family home as described in section (1)(a)(G) of this rule.

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

(4) TRANSITION. A child whose score on the clinical criteria remains at less than 30 is transitioned out of MFC services within 60 days. The child must exit from MFC services at the end of the 60 day transition period:

(a) When possible and agreed upon by the parent and the services coordinator, MFC services may be incrementally reduced during the 60 day transition period.

(b) The services coordinator must coordinate and attend a transition planning meeting at least 30 days prior to the end of the transition period. The transition planning meeting must include a CDDP representative, the parent, and any other person at the request of the parent.

(5) EXIT.

(a) MFC may be terminated:

(A) At the oral or written request of a parent to end the service relationship; or

(B) In any of the following circumstances:

(i) A child no longer meets the eligibility criteria in section (1) of this rule;

(ii) A child does not require waiver services or Community First Choice state plan services;

(iii) There are sufficient family, government, or community resources available to provide for the care of a child;

(iv) A child is not able to be safely served in the family home as described in section (1)(a)(G) of this rule;

(v) A parent either cannot be located or has not responded after 30 days of repeated attempts by a services coordinator to complete ISP development or monitoring activities;

(vi) A child is incarcerated or admitted to a medical hospital, psychiatric hospital, sub-acute facility, nursing facility, intermediate care facility for individuals with

intellectual or developmental disabilities, foster home, or other 24-hour residential program and it is determined that the child is not returning to the family home or is not returning to the family home after 90 consecutive days; or

(vii) A child does not reside in Oregon.

(b) In the event MFC are terminated, a written Notification of Planned Action must be provided as described in OAR chapter 411, division 318.

(6) WAIT LIST. If the maximum number of children allowed on the Hospital Model Waiver are enrolled and being served, the Department may place a child eligible for MFC services on a wait list. A child on the wait list may access other Medicaid-funded services for which the child is determined eligible such as waiver services, state plan personal care, or Community First Choice state plan services.

(a) The date of the initial completed application for MFC services determines the order on the wait list. A child who previously received MFC services that currently meets eligibility as described in section (1) of this rule is put on the wait list as of the date the original application for MFC services was complete.

(b) Children on the wait list are served on a first come, first served basis as space on the Hospital Model Waiver allows. A re-evaluation is completed prior to enrollment to determine current eligibility.

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

411-350-0040 Service Planning
(Temporary Effective 08/20/2014 to 02/16/2015)

(1) FUNCTIONAL NEEDS ASSESSMENT. To assess the service needs of a child, a services coordinator must complete a functional needs assessment using a person-centered planning approach.

(a) The functional needs assessment must be conducted face-to-face with the child and the services coordinator must interview the parent, other caregivers, and when appropriate, any other person at the request of the parent.

(b) The functional needs assessment must be completed:

(A) Within 30 days of entry into MFC services;

(B) Within 60 days prior to the annual renewal of an ISP; and

(C) Within 45 days from the date the parent requests a functional needs reassessment.

(c) The services coordinator must notify the parent of the need for a reassessment at least 14 days prior to the expiration of the most recent assessment.

(d) The parent must participate in the functional needs assessment and provide information necessary to complete the functional needs assessment within the time frame required by the Department.

(A) Failure to participate in the functional needs assessment or provide information necessary to complete the functional needs assessment within the applicable time frame results in a denial of service eligibility. In the event service eligibility is denied, a written Notification of Planned Action must be provided as described in OAR 411-318-0020.

(B) The Department may allow additional time if circumstances beyond the control of the parent prevent timely participation in

the functional needs assessment or timely submission of information necessary to complete the functional needs assessment.

(2) INDIVIDUAL SUPPORT PLAN.

(a) A child who is accessing waiver or Community First Choice state plan services must have an authorized ISP.

(A) The ISP must be facilitated, developed, and authorized by a services coordinator.

(B) The initial ISP must be authorized no later than the end of the month following the month in which the level of care determination was made.

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

(A) The service needs of the child;

(B) The most cost effective services for safely and appropriately meeting the service needs of the child; and

(C) The methods, resources, and strategies that address the service needs of the child.

(c) The ISP must include:

(A) The name of the child and the parent or legal guardian of the child;

(B) A description of the supports required that is consistent with the support needs identified in the assessment of the child, including the reason the support is necessary;

(C) The projected dates of when specific supports are to begin and end;

(D) 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;

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

(F) The maximum hours of or units of provider services determined necessary by a functional needs assessment;

(G) The providers of supports to be purchased with MFC funds or the type of provider, such as an independent provider, provider organization, or general business provider, when the provider is unknown or is likely to change frequently;

(H) Additional services authorized by the Department for the child;

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

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

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

(J) 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;

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

(L) The strengths and preferences of the child;

(M) Individually identified goals and desired outcomes of the child;

(N) 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;

(O) The risk factors and the measures in place to minimize the risk factors including back-up plans and frequency of risk monitoring;

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

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

(R) A provision to prevent unnecessary or inappropriate services; and

(S) Any changes in service needs identified through a functional needs assessment.

(d) An ISP must be reviewed with the parent prior to implementation. The parent and the services coordinator must sign the ISP. A copy of the ISP must be provided to the parent.

(e) The ISP must be understandable to the family and the people important in supporting the individual. An ISP is translated, as necessary, upon request.

(f) Changes in services authorized in the ISP must be consistent with needs identified in a functional needs assessment and documented in an amendment to the ISP that is signed by the parent and the services coordinator.

(g) An ISP must be renewed at least every 12 months. Each new plan year begins on the anniversary date of the initial or previous ISP.

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

411-350-0050 Scope of Medically Fragile Children's Services and Limitations
(Temporary Effective 08/20/2014 to 02/16/2015)

(1) MFC services are intended to support, not supplant, the naturally occurring care provided by a legally responsible primary caregiver and enable the primary caregiver to meet the disability-related needs of the child. MFC services are not meant to replace other available governmental or community services and supports.

(2) The functional needs assessment and MFC criteria determine the total number of hours needed to meet the identified needs of a child. The amount of hours may not be exceeded without prior approval from the Department. The types of services that contribute to the total of hours used include attendant care, skills training, and hourly relief care.

(3) MFC services are only authorized to enable the primary caregiver of a child to meet the needs of caring for a child on the Hospital Model Waiver. All services funded by the Department must be provided in accordance with the expenditure guidelines and based on the actual and customary costs related to best practice standards of care for children with similar disabilities.

(4) To be authorized and eligible for payment by the Department, all MFC supports and services must be:

(a) Directly related to the disability of a child;

(b) Required to maintain the health and safety of a child;

(c) Cost effective;

(d) Considered not typical for a parent to provide to a child of the same age;

(e) Required to help the parent to continue to meet the needs of caring for a child; and

(f) Included in an approved ISP.

(5) MFC services may include a combination of the following services based upon the needs of a child as determined by a services coordinator and consistent with a functional needs assessment and an initial or annual ISP:

(a) Community First Choice state plan services:

(A) Behavior support services as described in section (6) of this rule;

(B) Community nursing services as described in section (7) of this rule;

(C) Environmental modifications as described in section (8) of this rule;

(D) Attendant care as described in section (9) of this rule;

(E) Skills training as described in section (10) of this rule;

(F) Relief care as described in section (11) of this rule;

(G) Assistive devices as described in section (12) of this rule;

(H) Assistive technology as described in section (13) of this rule;

(I) Chore services as described in section (14) of this rule;

(J) Community transportation as described in section (15) of this rule; and

(K) Transition costs as described in section (16).

(b) WAIVER SERVICES:

(A) Case management as defined in OAR 411-350-0020;

(B) Family training as described in section (17) of this rule;

(C) Special diet as described in section (18) of this rule;

(D) Individual-directed goods and services as described in section (19) of this rule;

(E) Specialized medical supplies as described in section (20) of this rule;

(F) Environmental safety modifications as described in section (21) of this rule; and

(G) Vehicle modifications as described in section (22) of this rule.

(c) State Plan services, including private duty nursing as described in section (23) of this rule, and personal care services as described in OAR chapter 411, division 034.

(6) BEHAVIOR SUPPORT SERVICES. Behavior support services may be authorized to support a primary caregiver in their caregiving role and to respond to specific problems identified by a child, primary caregiver, or a services coordinator. Positive behavior support services are used to allow a child to develop, maintain, or enhance skills to accomplish ADLs, IADLs, and health-related tasks.

(a) A behavior consultant must:

(A) Work with the child and primary caregiver to identify:

(i) Areas of the family home life that are of most concern for the child and the parent;

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

(iii) The unique characteristics of the child and family that may influence the responses that may work with the child.

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

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

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

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

(iv) Identification of the probable reasons that are causing the behavior and the needs of the child that are 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.

(v) 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

(vi) An assessment of current communication strategies.

(C) Develop a variety of positive strategies that assist the primary caregiver and the provider to help the child use acceptable, alternative actions to meet the needs of the child in the safest, most positive, and cost effective manner. These strategies may include changes in the physical and social environment, developing effective communication, and

appropriate responses by the primary caregiver and the provider to the early warning signs.

(i) When interventions in behavior are necessary, the interventions must be done in accordance with positive behavioral theory and practice as defined in OAR 411-350-0020.

(ii) The least intrusive intervention possible to keep the child and others safe must be used.

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

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

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

(E) Develop emergency and crisis procedures to be used to keep the child and the primary caregiver and the provider safe. When interventions in the behavior of the child are necessary, positive, preventative, non-aversive interventions that conform to OIS must be utilized. The use of protective physical intervention must be part of the Behavior Support Plan for the child. When protective physical intervention is required, the protective physical intervention must only be used as a last resort and the provider must be appropriately trained in OIS;

(F) Teach the primary caregiver and the provider the strategies and procedures to be used; and

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

(b) Behavior support services may include:

(A) Training, modeling, and mentoring the family of a child;

(B) Developing a visual communication system as a strategy for behavior support; and

(C) Communicating, as authorized by a parent, with school, medical, or other professionals about the strategies and outcomes of the Behavior Support Plan.

(c) Behavior support services exclude:

(A) Mental health therapy or counseling;

(B) Health or mental health plan coverage;

(C) Educational services including, but not limited to, consultation and training for classroom staff;

(D) Adaptations to meet the needs of a child at school;

(E) An assessment in a school setting;

(F) Attendant care; or

(G) Relief care.

(7) COMMUNITY NURSING SERVICES.

(a) Community nursing services include:

(A) Nursing assessments, including medication reviews;

(B) Care coordination;

(C) Monitoring;

(D) Development of a Nursing Services Plan;

(E) Delegation and training of nursing tasks to a provider and primary caregiver;

(F) Teaching and education of the parent and provider and identifying supports that minimize health risks while promoting the autonomy of a child and self-management of healthcare; and

(G) Collateral contact with a services coordinator regarding the community health status of a child to assist in monitoring safety and well-being and to address needed changes to the ISP for the child.

(b) Community nursing services exclude private duty nursing care.

(c) A Nursing Service Plan must be present when MFC funds are used for community nursing services. A services coordinator must authorize the provision of community nursing services as identified in an ISP.

(d) After an initial nursing assessment, a nursing reassessment must be completed very six months or sooner if a change in a medical condition requires an update to the Nursing Service Plan.

(8) ENVIRONMENTAL MODIFICATIONS.

(a) Environmental modifications include, but are not limited to:

(A) Installation of shatter-proof windows;

(B) Hardening of walls or doors;

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

(D) An alarm system for doors or windows;

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

(F) Sound and visual monitoring systems;

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

(H) Adaptation of kitchen cabinets and sinks;

(I) Widening of doorways;

(J) Handrails;

(K) Modification of bathroom facilities;

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

(M) Installation of non-skid surfaces;

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

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

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

(b) Environmental modifications may include the cost of a professional consultation if required to determine the appropriate type of modification to ensure the health, welfare, and safety of the child. The cost of professional consultation may be included in the purchase price.

(c) Environmental modifications 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 such as carpeting, roof repair, and central air conditioning;

(B) Adaptations that add to the total square footage of the family home;

(C) Adaptations outside of the family home, except for ramps that attach to the family home for the purpose of entering and exiting the family home; and

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

(d) 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 service needs and goals of the child and the determination by the Department of appropriateness and cost-effectiveness.

(e) Environmental modifications must be tied to supporting ADL, IADL, and health-related tasks as identified in the ISP.

(f) Environmental modifications 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 file for the contractor prior to payment.

(g) Environmental modifications must be made within the existing square footage of the family home, except for external ramps, and may not add to the square footage of the family home.

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

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

(9) ATTENDANT CARE. Attendant care services include direct support provided to a child in the family home or community by a qualified independent provider or provider organization. ADL and IADL services provided through attendant care must support the child to live as independently as appropriate for the age of the child, support the family in their primary caregiver role, and be based on the identified needs of the child. The primary caregiver is expected to be present or available during the provision of attendant care.

(a) ADL services include, but are not limited to:

(A) Basic personal hygiene - providing or assisting with needs such as bathing (tub, bed, bath, shower), hair care, grooming, shaving, nail care, foot care, dressing, skin care, or oral hygiene;

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

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

(D) Nutrition - assisting with adequate fluid intake or adequate nutrition, assisting with food intake (feeding), monitoring to prevent choking or aspiration, assisting with adaptive utensils, cutting food, and placing food, dishes, and utensils within reach for eating;

(E) Medication and medical equipment - assisting with ordering, organizing, and administering medications (including pills, drops, ointments, creams, injections, inhalers, and suppositories), monitoring a child for choking while taking medications, assisting with the administration of medications, maintaining equipment, or monitoring for adequate medication supply;

(F) Delegated nursing tasks;

(G) First aid and handling emergencies - addressing medical incidents related to the conditions of a child, such as seizure, aspiration, constipation, or dehydration, responding to the call of the child for help during an emergent situation, or for unscheduled needs requiring immediate response;

(H) Assistance with necessary medical appointments - help scheduling appointments, arranging medical transportation services, accompaniment to appointments, follow up from appointments, or assistance with mobility, transfers, or cognition in getting to and from appointments; and

(I) Observation of the status of a child and reporting of significant changes to a physician, health care professional, or other appropriate person.

(b) IADL services include, but are not limited to, the following services provided solely for the benefit of the child:

(A) Light housekeeping tasks necessary to maintain a child in a healthy and safe environment - cleaning surfaces and floors, making the child's bed, cleaning dishes, taking out the garbage, dusting, and laundry;

(B) Grocery and other shopping necessary for the completion of other ADL and IADL tasks;

(C) Meal preparation and special diets;

(D) Cognitive assistance or emotional support provided to a child due to an intellectual or developmental disability - helping the child cope with change and assisting the child with decision-making, reassurance, orientation, memory, or other cognitive functions;

(E) Social support in the community around socialization and participation in the community:

(i) Support with socialization - assisting a child in acquiring, retaining, and improving self-awareness and

self-control, social responsiveness, social amenities, and interpersonal skills;

(ii) Support with community participation - assisting a child in acquiring, retaining, and improving skills to use available community resources, facilities, or businesses; and

(iii) Support with communication - assisting a child in acquiring, retaining, and improving expressive and receptive skills in verbal and non-verbal language and the functional application of acquired reading and writing skills.

(c) Assistance with ADLs and IADLs may include cueing, monitoring, reassurance, redirection, set-up, hands-on, or standby assistance. Assistance may be provided through human assistance or the use of electronic devices or other assistive devices. Assistance may also require verbal reminding to complete any of the IADL tasks described in subsection (b) of this section.

(A) "Cueing" means giving verbal, audio, or visual clues during an activity to help a child complete the activity without hands-on assistance.

(B) "Hands-on" means a provider physically performs all or parts of an activity because a child is unable to do so.

(C) "Monitoring" means a provider observes a child to determine if assistance is needed.

(D) "Reassurance" means to offer a child encouragement and support.

(E) "Redirection" means to divert a child to another more appropriate activity.

(F) "Set-up" means the preparation, cleaning, and maintenance of personal effects, supplies, assistive devices, or equipment so that a child may perform an activity.

(G) "Stand-by" means a provider is at the side of a child ready to step in and take over the task if the child is unable to complete the task independently.

(d) 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.

(e) Attendant care services exclude:

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

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

(C) Hours that exceed what is necessary to support the child based on the functional needs assessment;

(D) Support generally provided for a child of similar age without disabilities by the parent or other family members;

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

(F) Services provided by the family; and

(G) Home schooling.

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

(10) SKILLS TRAINING. Skills training is specifically tied to accomplishing ADL, IADL, and other health-related skills as identified by the functional needs assessment and ISP and is a means for a child to acquire, maintain, or enhance independence.

(a) Skills training may be applied to the use and care of assistive devices and technologies.

(b) Skills training is authorized when:

(A) The anticipated outcome of the skills training, as documented in the ISP, is measurable;

(B) Timelines for measuring progress towards the anticipated outcome are established in the ISP; and

(C) Progress towards the anticipated outcome are measured and the measurements are evaluated by a services coordinator

no less frequently than every six months, based on the start date of the initiation of the skills training.

(c) When anticipated outcomes are not achieved, the services coordinator must reassess the use of skills training with the individual.

(d) Skills training do not replace the responsibilities of the school system.

(11) RELIEF CARE.

(a) Relief care includes two types of care, neither of which may be characterized as daily or periodic services.

(A) Twenty-four hour relief care must be provided in segments of 24-hour units that may be sequential but may not exceed seven consecutive days without permission from the Department.

(B) Hourly relief care is substitute care for the care provided by the primary caregiver.

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

(A) The family home;

(B) A setting licensed or certified by the Department;

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

(D) The community, during the provision of ADL, IADL, health-related tasks, and other supports identified in the ISP for the child.

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

(A) Solely to allow the primary caregiver of the child to attend school or work;

(B) For more than 14 consecutive overnight stays;

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

(D) For vacation, travel, and lodging expenses; or

(E) To pay for room and board.

(12) ASSISTIVE DEVICES. Assistive devices are primarily and customarily used to meet an ADL, IADL, or health-related support need. The purchase, rental, or repair of an assistive device must be limited to the types of equipment that are not excluded under OAR 410-122-0080.

(a) Assistive devices may be purchased with MFC funds when the intellectual or developmental disability of a child prevents or limits the independence of the child to assist in areas identified in a functional needs assessment.

(b) Assistive devices that may be purchased for the purpose described in section (a) of this rule must be of direct benefit to the child and may 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.

(i) Expenditures for electronic devices are limited to $500 per plan year.

(ii) A services coordinator may request approval for additional expenditures through the Department prior to expenditure.

(B) Assistive devices not covered by other Medicaid programs to assist and enhance the independence of a child in performing ADLs or IADLs such as durable medical equipment, mechanical apparatus, or electronic 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.

(c) Assistive devices 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.

(d) To be authorized by a services coordinator, assistive devices must be:

(A) Not covered by the Medicaid State Plan, OHP, or private insurance;

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

(C) Directly related to the disability of a child.

(e) Assistive devices exclude:

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

(B) Items intended to supplant similar items furnished under OHP or private insurance;

(C) Items available through the 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.

(f) Funding for assistive devices with an expected life of more than one year is one time funding that is not continued in subsequent plan years. Assistive devices may only be included in an ISP when all other public and private resources have been exhausted.

(g) A services coordinator must secure use of assistive devices costing more than $500 through a written agreement between the Department and the 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 assistive devices purchased with CIIS funds that are not used according to the ISP for the child or according to the written agreement between the Department and the parent.

(h) Assistive devices must meet applicable standards of manufacture, design, and installation.

(13) ASSISTIVE TECHNOLOGY.

(a) Assistive technology includes, but is not limited to, motion or sound sensors, two-way communication systems, automatic faucets and soap dispensers, incontinent and fall sensors, or other electronic backup systems.

(A) 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.

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

(b) Assistive technology 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.

(c) To be authorized by a services coordinator, assistive technology must be:

(A) Not covered by the Medicaid State Plan, OHP, or private insurance;

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

(C) Directly related to the disability of a child.

(d) Assistive technology excludes:

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

(B) Items intended to supplant similar items furnished under OHP or private insurance;

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

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

(E) Equipment and furnishings of general household use.

(e) Funding for assistive technology with an expected life of more than one year is one time funding that is not continued in subsequent plan years. Assistive technology may only be included in an ISP when all other public and private resources have been exhausted.

(f) A services coordinator must secure use of assistive technology costing more than $500 through a written agreement between the Department and the 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 assistive technology purchased with MFC funds that is not used according to the ISP of the child or according to the written agreement between the Department and the parent.

(g) Assistive technology must meet applicable standards of manufacture, design, and installation.

(14) CHORE SERVICES. Chore services may be provided only in situations where no one else in the 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 the family home is safe for the child to traverse and enter and exit the home.

(15) COMMUNITY TRANSPORTATION.

(a) Community transportation services include, but are not limited to:

(A) Community transportation provided by a common carrier, taxicab, or bus in accordance with standards established for these entities;

(B) Reimbursement on a per-mile basis for transporting a child to accomplish ADL, IADL, or a health-related task as identified in an ISP; or

(C) Assistance with the purchase of a bus pass.

(b) Mileage reimbursement must be limited to those destinations where other members of the local community of the child would typically get similar services.

(c) Community transportation must be prior authorized by a services coordinator and documented in an ISP. The Department does not pay

any provider under any circumstances for more than the total number of hours, miles, or rides prior authorized by the services coordinator and documented in the ISP. Personal support workers who use their own personal vehicles for community transportation are reimbursed as described in OAR chapter 411, division 375.

(d) Community transportation excludes:

(A) Transportation provided by family members;

(B) Transportation used for behavioral intervention or calming;

(C) Transportation normally provided by schools;

(D) Transportation normally provided by a primary caregiver for a child of similar age without disabilities;

(E) Transportation to obtain medical or non-medical items that may be delivered by a supplier or sent by mail order without cost;

(F) Purchase or lease of a vehicle;

(G) Routine vehicle maintenance and repair;

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

(I) Ambulance services or medical transportation;

(J) Transportation services that may be obtained through other means such as OHP or other public or private resources available to the child; and

(K) Costs for transporting a person other than the child.

(16) TRANSITION COSTS.

(a) Transition costs are limited to a child transitioning to the family home from a nursing facility, intermediate care facility for individuals with intellectual or developmental disabilities, or acute care hospital.

(b) Transition costs are based on the assessed need of a child determined during the person-centered service planning process and must support the desires and goals of the child receiving services and supports. Final approval for transition costs must be through the Department prior to expenditure. The approval of the Department is based on the need of the child and the determination of appropriateness and cost-effectiveness.

(c) Financial assistance for transition costs is limited to:

(A) Moving and move-in costs including movers, cleaning and security deposits, payment for background or credit checks (related to housing), or initial deposits for heating, lighting, and phone;

(B) Payment of previous utility bills that may prevent the individual from receiving utility services and basic household furnishings such as a bed; and

(C) Other items necessary to re-establish a home.

(d) Transition costs are provided no more than twice annually.

(e) Transitions costs for basic household furnishings and other items are limited to one time per year.

(17) FAMILY TRAINING. Family training services are provided to the family of a child to increase the abilities of the family to care for, support, and maintain the child in the family home.

(a) Family training services include:

(A) Instruction about treatment regimens and use of equipment specified in an ISP;

(B) Information, education, and training about the disability, medical, and behavioral conditions of a child; and

(C) Registration fees for organized conferences and workshops specifically related to the intellectual or developmental disability of the child or the identified, specialized, medical, or behavioral support needs of the child.

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

(ii) Conference and workshop, 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.

(b) Family training services exclude:

(A) Mental health counseling, treatment, or therapy;

(B) Training for a paid provider;

(C) Legal fees;

(D) Training for a family to carry out educational activities in lieu of school;

(E) Vocational training for family members; and

(F) Paying for training to carry out activities that constitute abuse of a child.

(18) SPECIAL DIET.

(a) A special diet is a supplement and is not intended to meet the complete, daily nutritional requirements for a child.

(b) A special diet must be ordered at least annually by a physician licensed by the Oregon Board of Medical Examiners and periodically monitored by a dietician or physician.

(c) The maximum monthly purchase for special diet supplies may not exceed $100 per month.

(d) Special diet supplies must be in support of an evidence-based treatment regimen.

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

(19) INDIVIDUAL-DIRECTED GOODS AND SERVICES.

(a) Individual-directed goods and services provide adaptive play equipment and materials that are not otherwise available through another source such as waiver services or state plan services.

(b) Individual-directed goods and services are therapeutic in nature and must be recommended by at least one licensed health professional or by a behavior consultant.

(c) Individual-directed goods and services must directly address the disability related needs of a child.

(d) Individual-directed goods and services must:

(A) Decrease the need for other Medicaid services;

(B) Promote inclusion of a child in the community; or

(C) Increase the safety of a child in the family home.

(e) Individual-directed goods and services may not be:

(A) Otherwise available through another source such as waiver services or state plan services;

(B) Experimental or prohibited treatment; or

(C) Goods or services that are normally purchased by a family for a typically developing child of the same age.

(f) Individual-directed goods and services purchased must be the most cost effective option available to meet the needs of the child.

(20) SPECIALIZED MEDICAL SUPPLIES. Specialized medical supplies do not cover services which are otherwise available to a child under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

Specialized medical supplies may not overlap, supplant, or duplicate other services provided through the waiver, OHP or Medicaid state plan services.

(21) ENVIRONMENTAL SAFETY MODIFICATIONS.

(a) Environmental safety modifications must be made from materials of the most cost effective type and may not include decorative additions.

(b) Fencing may not exceed 200 linear feet without approval from the Department.

(c) Environmental safety modifications exclude:

(A) Large gates such as automobile gates;

(B) Costs for paint and stain;

(C) 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; and

(D) Adaptations that add to the total square footage of the family home.

(d) Environmental safety 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 service needs and goals of the child and the determination by the Department of appropriateness and cost-effectiveness.

(e) Environmental safety modifications must be tied to supporting ADL, IADL, and health-related tasks as identified in the ISP.

(f) Environmental safety modifications 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 file for the contractor prior to payment.

(g) Environmental safety modifications must be made within the existing square footage of the family home and may not add to the square footage of the family home.

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

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

(22) VEHICLE MODIFICATIONS.

(a) Vehicle modifications may only be made to the vehicle primarily used by a child to meet the unique needs of the child. Vehicle modifications may include a lift, interior alterations to seats, head and leg rests, belts, special safety harnesses, other unique modifications to keep the child safe in the vehicle, and the upkeep and maintenance of a modification made to the vehicle.

(b) Vehicle modifications exclude:

(A) Adaptations or improvements to a vehicle that are of general utility and are not of direct medical or remedial benefit to a child;

(B) The purchase or lease of a vehicle; or

(C) Routine vehicle maintenance and repair.

(c) Vehicle 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 service needs and goals of the child and the determination by the Department of appropriateness and cost-effectiveness.

(d) Vehicle modifications must meet applicable standards of manufacture, design, and installation.

(23) PRIVATE DUTY NURSING. If the service needs of a child require the presence of an RN or LPN on an ongoing basis as determined medically necessary based on the assessed needs of the child, private duty nursing services may be allocated to ensure medically necessary supports are provided.

(a) Private duty nursing may be provided on a shift staffing basis as necessary.

(b) Private duty nursing must be delivered by a licensed RN or LPN, as determined by the service needs of the child and documented in the ISP and Nursing Service Plan.

(c) The amount of private duty nursing available to a child is based on the acuity level of the child as measured by the clinical criteria as follows:

(A) Level 1. Score of 75 or greater and on a ventilator for 20 hours or more per day = up to a maximum of 554 nursing hours per month;

(B) Level 2. Score of 70 to 74 = up to a maximum of 462 nursing hours per month;

(C) Level 3. Score of 65 to 69 = up to a maximum of 385 nursing hours per month;

(D) Level 4. Score of 60 to 64 = up to a maximum of 339 nursing hours per month;

(E) Level 5. Score of 50 to 59 or if a child requires ventilation for sleeping hours = up to a maximum of 293 nursing hours per month; and

(F) Level 6. Score of less than 50 = up to a maximum of 140 nursing hours per month.

(24) 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 and appropriately meeting the service needs of a child as determined by a services coordinator.

(25) All requests for General Fund expenditures and expenditures exceeding limitations in the expenditure guidelines must be authorized by the Department. The approval of the Department is limited to 90 days unless re-authorized. Exceptions associated with criteria hours may be approved for up to six months to align with the criteria redetermination. A request for a General Fund expenditure or an expenditure exceeding limitations in the expenditure guidelines is only authorized in the following circumstances:

(a) To prevent the hospitalization of a child;

(b) To provide initial teaching of new service needs;

(c) The child is not safely served in the family home without the expenditure;

(d) The expenditure provides supports for the emerging or changing service needs or behaviors of the child;

(e) A significant medical condition or event occurs that prevents or seriously impedes the primary caregiver from providing services as documented by a physician; or (f) The services coordinator determines, with a behavior consultant, that the child needs two staff present at one time to ensure the safety of the child and others. Prior to approval, the services coordinator must determine that a caregiver, including the parent, has been trained in behavior management and that all other feasible recommendations from the behavior consultant and the services coordinator have been implemented.

(26) The Department may expend funds through contract, purchase order, use of credit card, payment directly to the vendor, or any other legal payment mechanism. No payments are made to families for reimbursement or to pay for services.

(27) 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 the needs of a child as determined by a services coordinator.

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

411-350-0075 Standards for Employers
(Temporary Effective 08/20/2014 to 02/16/2015)

(1) EMPLOYEE –RELATIONSHIP. The relationship between an independent provider and a parent, or a person selected by the parent to

act on the behalf of the parent to provide the employer responsibilities described in section (5)(a) of this rule, is that of employee and employer.

(a) A personal support worker who is not an independent contractor must have an employer of record. The Department may not act as the employer of record.

(b) Independent providers, including personal support workers, are not state, CDDP, or brokerage employees.

(2) JOB DESCRIPTION. The employer must create and maintain a job description for an independent provider that is in coordination with the services authorized in the ISP.

(3) BENEFITS. Only personal support workers qualify for benefits. The benefits provided to personal support workers are described in OAR chapter 411, division 375.

(4) INTERVENTION. For the purpose of this rule, "intervention" means the action the Department or the designee of the Department requires when an employer fails to meet the employer responsibilities described in this rule. Intervention includes, but is not limited to:

(a) A documented review of the employer responsibilities described in section (5) of this rule;

(b) Training related to employer responsibilities;

(c) Corrective action taken as a result of an independent provider filing a complaint with the Department, the designee of the Department, or other agency who may receive labor related complaints;

(d) Identifying an employer representative if a person is not able to meet the employer responsibilities described in section (5) of this rule; or

(e) Identifying another representative if the current employer representative is not able to meet the employer responsibilities described in section (5) of this rule.

(5) EMPLOYER RESPONSIBILITIES.

(a) For a child to be eligible for MFC provided by an employed independent provider, an employer must demonstrate the ability to:

(A) Locate, screen, and hire a qualified independent provider;

(B) Supervise and train the independent provider;

(C) Schedule work, leave, and coverage;

(D) Track the hours worked and verify the authorized hours completed by the independent provider;

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

(F) Discharge an unsatisfactory independent provider.

(b) Indicators that an employer may not be meeting the employer responsibilities described in subsection (a) of this section include, but are not limited to:

(A) Independent provider complaints;

(B) Multiple complaints from an independent provider requiring intervention from the Department as defined in section (4) of this rule;

(C) Frequent errors on time sheets, mileage logs, or other required documents submitted for payment that results in repeated coaching from the Department;

(D) Complaints to Medicaid Fraud involving the employer; or

(E) Documented observation by the Department of services not being delivered as identified in an ISP.

(c) The Department may require intervention as defined in section (4) of this rule when an employer has demonstrated difficulty meeting the employer responsibilities described in subsection (a) of this section.

(d) A child may not receive MFC services provided by an independent provider if, after appropriate intervention and assistance, an employer is not able to meet the employer responsibilities described in subsection (a) of this section. The child may receive MFC services provided by a provider organization or general business provider, when available.

(6) DESIGNATION OF EMPLOYER RESPONSIBLITIES.

(a) A parent not able to meet all of the employer responsibilities described in section (5)(a) of this rule must:

(A) Designate an employer representative in order for the child to receive or continue to receive MFC services provided by an independent provider; or

(B) Select a provider organization or general business provider to provide MFC services.

(b) A parent able to demonstrate the ability to meet some of the employer responsibilities described in section (5)(a) of this rule must:

(A) Designate an employer representative to fulfill the responsibilities the parent is not able to meet in order for the child to receive or continue to receive MFC services provided by an independent provider; and

(B) On a Department approved form, document the specific employer responsibilities to be performed by the parent and the employer responsibilities to be performed by the employer representative.

(c) When an employer representative is not able to meet the employer responsibilities described in section (5)(a) or the qualifications in section (7)(c) of this rule, the parent must:

(A) Designate a different employer representative in order for the child to receive or continue to receive MFC services provided by an independent provider; or

(B) Select a provider organization or general business provider to provide MFC services.

(7) EMPLOYER REPRESENTATIVE.

(a) A parent may designate an employer representative to act on behalf of the parent to meet the employer responsibilities described in section (5)(a) of this rule.

(b) If an independent provider is selected by the parent to act as the employer, the parent must seek an alternate employer for purposes of the employment of the independent provider. The alternate employer must:

(A) Track the hours worked and verify the authorized hours completed by the independent provider; and

(B) Document the specific employer responsibilities performed by the employer on a Department approved form.

(c) The Department may suspend, terminate, or deny a request for an employer representative if the requested employer representative has:

(A) A founded report of child abuse or substantiated abuse;

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

(C) Failed to meet the employer responsibilities in section (5)(a) or (7)(b) of this rule, including previous termination as a result of failing to meet the employer responsibilities in section (5)(a) or (7)(b).

(d) If the Department suspends, terminates, or denies a request for an employer representative for the reasons described in subsection (c) of this section, the parent may select another employer representative.

(8) NOTICE.

(a) The Department shall mail a notice to the parent when:

(A) The Department denies, suspends, or terminates an employer from performing the employer responsibilities described in sections (5)(a) or (7)(b) of this rule; and

(B) The Department denies, suspends, or terminates an employer representative from performing the employer

responsibilities described in section (5)(a) or (7)(b) of this rule because the employer representative does not meet the qualifications in section (7)(c) of this rule.

(b) If the parent does not agree with the action taken by the Department, the parent may request an administrator review.

(A) The request for an administrator review must be made in writing and received by the Department within 45 days from the date of the notice.

(B) The determination of the Director is issued in writing within 30 days from the date the written request for an administrator review was received by the Department.

(C) The determination of the Director is the final response from the Department.

(c) When a denial, suspension, or termination of an employer results in the Department denying, suspending, or terminating a child from MFC services, the hearing rights in OAR chapter 411, division 318 apply.

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

411-350-0080 Standards for MFC Providers
(Temporary Effective 08/20/2014 to 02/16/2015)

(1) PERSONAL SUPPORT WORKER QUALIFICATIONS. A personal support worker must meet the qualifications described in OAR chapter 411, division 375.

(2) INDEPENDENT PROVIDER QUALIFICATIONS. An independent provider who is not a personal support worker who is paid as a contractor or a self-employed person and selected to provide MFC services must:

(a) Be at least 18 years of age;

(b) Have approval to work based on current Department policy and a background check completed by the Department in accordance with OAR 407-007-0200 to 407-007-0370. 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;

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

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

(e) Not be the primary caregiver, parent, stepparent, spouse, or legal guardian of a child;

(f) Demonstrate by background, education, references, skills, and abilities that he or she is capable of safely and adequately performing the tasks specified in an ISP, with such demonstration confirmed in writing by the parent, including:

(A) Ability and sufficient education to follow oral and written instructions and keep any required records;

(B) Responsibility, maturity, and reputable character exercising sound judgment;

(C) Ability to communicate with the parent; and

(D) Training of a nature and type sufficient to ensure that the provider has knowledge of emergency procedures specific to the child.

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

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

(i) Not be on the Office of Inspector General's list of excluded or debarred providers (http://exclusions.oig.hhs.gov/);

(j) If providing transportation, have a valid driver's license and proof of insurance as well as any other license or certification that may be required under state and local law depending on the nature and scope of the transportation service; and

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

(3) Section (2)(c) of this rule does not apply to employees of an employer as defined in OAR 411-350-0020, employees of general business providers, or employees of provider organizations, who were hired prior to July 28, 2009 that remain in the current position for which the employee was hired.

(4) 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 designee of the Department within 24 hours.

(5) If a provider is an independent contractor during the terms of a contract, the provider must maintain in force, at the expense of the provider, 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 must provide written evidence of insurance coverage to the Department prior to beginning work and at any time upon the request of the Department.

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

(6) A provider must immediately notify the 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 MFC services are being provided.

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

(8) BEHAVIOR CONSULTANTS. Behavior consultants providing specialized consultations must:

(a) Have education, skills, and abilities necessary to provide behavior support services as outlined in OAR 411-350-0050;

(b) Have current certification demonstrating completion of OIS training; and

(c) Submit a resume or the equivalent to the Department indicating at least one of the following:

(A) A bachelor's degree in special education, psychology, speech and communication, occupational therapy, recreation, art or music therapy, or a behavioral science or related field, and at least one year of experience with individuals with disabilities who present difficult or dangerous behaviors; or

(B) Three years of experience with individuals with disabilities who present difficult or dangerous behaviors and at least one year of that experience includes providing the services of a behavior consultant as outlined in OAR 411-350-0050.

(d) Additional education or experience may be required to safely and adequately provide the services described in OAR 411-350-0050.

(9) COMMUNITY NURSE. A nurse providing community nursing services must be an enrolled Medicaid provider and meet the qualifications in OAR 411-048-0210.

(10) DIETICIANS. Dieticians providing special diets must be licensed according to ORS 691.415 through 691.465.

(11) PROVIDER ORGANIZATIONS WITH CURRENT LICENSE OR CERTIFICATION. A provider organization certified, licensed, and endorsed under OAR chapter 411, division 325 for 24-hour residential services, or licensed under OAR chapter 411, division 360 for adult foster homes, or certified and endorsed under OAR chapter 411, division 345 for employment and day support activities, or OAR chapter 411, division 328 for supported living services, or OAR 411-340-0170 for support services, may not require additional certification as an organization to provide relief care, attendant care, skills training, community transportation, or behavior support services.

(a) Current license, certification, or endorsement is considered sufficient demonstration of ability to:

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

(B) Provide services according to ISPs; and

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

(b) Provider organizations must assure that all people directed by the provider organization as employees, contractors, or volunteers to provide services paid for with MFC funds meet the standards for independent providers described in section (2) of this rule.

(12) General business providers providing services to children paid with MFC funds including, but not limited to the following, must hold any current license appropriate to operate required by the state of Oregon or federal law or regulation.

(a) Home health agencies must be licensed under ORS 443.015.

(b) In-home care agencies must be licensed under ORS 443.315.

(c) For providers of environmental modifications involving building modifications or new construction, a current license and bond as a building contractor as required by either OAR chapter 812 (Construction Contractor's Board) or OAR chapter 808 (Landscape Contractors Board).

(d) For environmental accessibility consultants, a current license as a general contractor as required by OAR chapter 812, including experience evaluating homes, assessing the needs of an individual, and developing cost-effective plans to make homes safe and accessible.

(e) Public transportation providers must be regulated according to established standards and private transportation providers must have a business license, vehicle insurance in compliance with the Department of Motor Vehicles, and drivers with a valid license to drive.

(f) Vendors and medical supply companies providing specialized medical equipment and supplies must have a current retail business license and, if vending medical equipment, be enrolled as Medicaid providers through the Division of Medical Assistance Programs.

(g) Providers of personal emergency response systems must have a current retail business license.

(h) Vendors and supply companies providing specialized diets must have a current retail business license.

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 MFC Documentation Needs
(Temporary Effective 08/20/2014 to 02/16/2015)

(1) Accurate timesheets of MFC services must be dated and signed by the provider and the parent of the child 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 the billing form indicating prior authorization for the services;

(b) Be signed by the 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 parent of the child after the services were delivered, verifying that the services were delivered as billed.

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

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

(5) A Nursing Service 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 Service 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 Service 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 Service Plan with the parent.

(6) 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.

(7) Behavior consultants must submit the following to the Department written in clear, concrete language understandable to the parent of the child and the provider:

(a) An evaluation of the child, the concerns of the parent, the environment of the child, current communication strategies used by the child and used by others with the child, and any other disability of the child that may impact the appropriateness of strategies to be used with the child; and

(b) Any behavior plan or instructions left with the parent or the provider that describes the suggested strategies to be used with the child.

(8) Providers must maintain documentation of provided services for at least seven years from the date of service. If a provider is a nurse, the nurse must either maintain documentation of provided services for at least five years or send the documentation to the Department.

(9) 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.

(10) Access to records by the Department including, but not limited to, medical, nursing, behavior, psychiatric, or financial records, to include

providers and vendors providing goods and services, does not require authorization or release by the child or the parent of the child.

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

411-350-0110 Payment for MFC
(Temporary Effective 08/20/2014 to 02/16/2015)

(1) Payment is made after MFC services are delivered as authorized.

(2) Effective July 28, 2009, MFC 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 an employee of a parent or a provider who was hired prior to July 28, 2009 that remains in the current position for which the employee was hired.

(4) MFC funds may not be used for:

(a) Services, supplies, or supports that are illegal, experimental, or determined unsafe for the general public by a recognized child or consumer safety agency;

(b) Services or activities that are carried out in a manner that constitutes abuse of a child;

(c) Services from a person who engages in verbal mistreatment and subjects a child to the use of derogatory names, phrases, profanity, ridicule, harassment, coercion, or intimidation by threatening injury or withholding of services or supports;

(d) Services that restrict the freedom of movement of a child by seclusion in a locked room under any condition;

(e) Purchase or lease of a vehicle;

(f) Purchase of a service animal or costs associated with the care of a service animal;

(g) Medical treatments;

(h) Health insurance co-payments and deductibles;

(i) Prescribed or over-the-counter medications;

(j) Mental health treatments and counseling;

(k) Dental treatments and appliances;

(l) Dietary supplements and vitamins;

(m) Supplies not related to nutrition, incontinence, or infection control;

(n) Ambulance service;

(o) Legal fees such as the cost of representation in educational negotiations, establishment of trusts, or creation of guardianship;

(p) Vacation costs or costs for recreation or leisure;

(q) Services, training, or supervision that has not been arranged according to applicable state and federal wage and hour regulations;

(r) Any purchase that is not generally accepted by the relevant mainstream professional or academic community as an effective means to address an identified support need;

(s) Unless under certain conditions and limits specified in an ISP, employee wages or contractor payments for services when a child is not present or available to receive services such as employee paid time off, hourly "no show" charge, or contractor travel and preparation hours;

(t) Services, activities, materials, or equipment that are not necessary, not in accordance with the expenditure guidelines, not cost effective, or do not meet the definition of support or social benefit as defined in OAR 411-350-0020;

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

(v) Services, activities, materials, or equipment that the Department determines may be reasonably obtained by a family through other available means such as private or public insurance, philanthropic organizations, or other governmental or public services;

(w) Services or activities for which the legislative or executive branch of Oregon government has prohibited use of public funds;

(x) Purchase of services when there is sufficient evidence to believe that a parent or a provider chosen by a family has engaged in fraud or misrepresentation, failed to use resources as agreed upon in the ISP for a child, refused to cooperate with record keeping required to document use of MFC funds, or otherwise knowingly misused public funds associated with MFC services; or

(y) Notwithstanding abuse as defined in ORS 419B.005, services that in the opinion of a services coordinator are characterized by failure to act or neglect that leads to or is in imminent danger of causing physical injury through negligent omission, treatment, or maltreatment of a child such as the failure to provide a child with adequate food,

clothing, shelter, medical services, supervision, or through condoning or permitting abuse of a child by any other person. However, no child may be considered neglected for the sole reason that a family relies on treatment through prayer alone in lieu of medical treatment.

(5) Payment for MFC services is made in accordance with the expenditure guidelines.

(6) Service levels are based on the individual needs of a child as identified by a functional needs assessment and authorized in the ISP for the child.

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

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

(9) The Department makes payment to the employee of a parent on behalf of the parent. The Department pays the employer's share of the Federal Insurance Contributions Act tax (FICA) and withholds FICA as a service to the parent, who is the employer. The Department covers real and actual costs to the Employment Department in lieu of the parent, who is the employer.

(10) 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 Department does not authorize services that require the payment of overtime without prior written authorization by the MFCU Supervisor.

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

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

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

(14) 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.

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

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

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

(18) 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.

(19) 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.

(20) Upon submission of the billing form for payment, a 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.

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

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

(23) A person may not submit the following 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.

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

(25) Payment is denied if any provisions of these rules are not complied with.

(26) 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 parent, the parent has the right to request a hearing as provided in ORS 183.

(27) 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, 430.215

411-350-0115 Rights, Complaints, Notification of Planned Action and Hearings
(Temporary Effective 08/20/2014 to 02/16/2015)

(1) RIGHTS OF THE CHILD.

(a) The rights of the child are described in OAR 411-318-0010.

(b) Upon enrollment, request, and annually thereafter, the individual rights described in OAR 411-318-0010 must be provided to the parent and the child.

(2) COMPLAINTS

(a) Complaints must be addressed in accordance with OAR 411-318-0015.

(b) Upon enrollment, request, and annually thereafter, the policy and procedures for complaints as described in OAR 411-318-0015 must be explained and provided to the parent of each child.

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

(4) HEARINGS.

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

(b) The parent of a child may request a hearing as provided in ORS chapter 183 and OAR 411-318-0025 for denials, reductions, suspensions, or terminations.

(c) Upon enrollment, request, and annually thereafter, a notice of hearing rights and the policy and procedures for hearings as described in OAR chapter 411, division 318 must be explained and provided to the parent of each child.

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
Suspended 08/20/2014
(Temporary Effective 08/20/2014 to 02/16/2015)

411-350-0120 MFC Provider Termination
(Temporary Effective 08/20/2014 to 02/16/2015)

(1) PERSONAL SUPPORT WORKER. Provider enrollment for a personal support worker must be terminated consistent with OAR chapter 411, division 375.

(2) INDEPENDENT PROVIDER WHO IS NOT A PERSONAL SUPPORT WORKER.

(a) The provider enrollment for an independent provider who is not a personal support worker may be inactivated in the following circumstances:

(A) The provider has not provided any paid services to a child within the last previous 12 months;

(B) The provider informs the Department that the provider is no longer providing services in Oregon;

(C) The background check for a provider results in a closed case pursuant to OAR 407-007-0325;

(D) Services provided to a child are being investigated by Adult or Child Protective Services for suspected abuse that poses imminent danger to current or future children; or

(E) Provider payments, all or in part, for the provider have been suspended based on a credible allegation of fraud or a conviction of fraud pursuant to federal law under 42 CFR 455.23.

(b) An independent provider who is not a personal support worker may have their provider enrollment terminated when the Department determines that, at some point after the initial qualification and authorization of the provider to provide supports purchased with MFC funds, the provider has:

(A) Been convicted of any crime that would have resulted in an unacceptable background check upon hiring or authorization of CIIS;

(B) Been convicted of unlawfully manufacturing, distributing, prescribing, or dispensing a controlled substance;

(C) Surrendered his or her professional license or had his or her professional license suspended, revoked, or otherwise limited;

(D) Failed to safely and adequately provide the authorized services;

(E) Had a founded report of child abuse or substantiated abuse;

(F) Failed to cooperate with any Department investigation or grant access to or furnish records or documentation, as requested;

(G) Billed excessive or fraudulent charges or been convicted of fraud;

(H) Made a false statement concerning conviction of a crime or substantiated abuse;

(I) Falsified required documentation;

(J) Been suspended or terminated as a provider by the Department or Oregon Health Authority;

(K) Violated the requirement to maintain a drug-free work place;

(L) Failed to provide services as required;

(M) Failed to provide a tax identification number or social security number that matches the legal name of the independent provider, as verified by the Internal Revenue Service or Social Security Administration; or

(N) Has been excluded or debarred by the Office of the Inspector General.

(c) If the Department makes a decision to terminate the provider enrollment of an independent provider who is not a personal support worker, the Department must issue a written notice

(A) The written notice must include:

(i) An explanation of the reason for termination of the provider enrollment;

(ii) The alleged violation as listed in section (a) or (b) of this rule; and

(iii) The appeal rights for the independent provider, including how to file an appeal.

(B) For terminations based on substantiated protective services allegations, the notice may only contain the limited information allowed by law. In accordance with ORS 124.075, 124.085, 124.090, and OAR 411-020-0030, complainants, witnesses, the name of the alleged victim, and protected health information may not be disclosed.

(d) The provider may appeal a termination within 30 days of the date the termination notice was mailed to the provider. The provider must appeal a termination separately from any appeal of audit findings and overpayments.

(A) A provider of Medicaid services may appeal a termination by requesting an administrator review.

(B) For an appeal regarding provision of Medicaid services to be valid, written notice of the appeal must be received by the Department within 30 days of the date the termination notice was mailed to the provider.

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

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