

# Application for a §1915(c) Home and Community-Based Services Waiver

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

No Major Changes.

## Application for a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information (1 of 3)

**A.** The **State of Oregon** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

**Behavioral (ICF/MR) Model Waiver**

**C. Type of Request:** renewal

**Requested Approval Period:** (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years  5 years

**Migration Waiver** - this is an existing approved waiver

**Renewal of Waiver:**

Provide the information about the original waiver being renewed

**Base Waiver Number:**

**Amendment Number**

(if applicable):

**Effective Date:** (*mm/dd/yy*)

**Waiver Number:** OR.40194.R02.00

**Draft ID:** OR.07.02.00

**Renewal Number:**

**D. Type of Waiver** (*select only one*):

**E.**

**Proposed Effective Date:** (*mm/dd/yy*)

04/01/09

Approved Effective Date: 04/01/09

**1. Request Information (2 of 3)**

**F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

 **Hospital**

Select applicable level of care

 **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

 **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160** **Nursing Facility**

Select applicable level of care

 **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

 **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140** **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

N/A

**1. Request Information (3 of 3)**

**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

 **Not applicable** **Applicable**

Check the applicable authority or authorities:

 **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I** **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*): §1915(b)(1) (mandated enrollment to managed care) §1915(b)(2) (central broker) §1915(b)(3) (employ cost savings to furnish additional services) §1915(b)(4) (selective contracting/limit number of providers) **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.  
 A program authorized under §1915(j) of the Act.  
 A program authorized under §1115 of the Act.

Specify the program:  
The Oregon Health Plan

#### H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

## 2. Brief Waiver Description

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**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Goals:

Children with significant behaviors who meet an initial score of 200 on the Behavioral Conditions Criteria (an assessment checklist) and do not subsequently fall below a score of 150. Prior authorization is required for all services.

Objectives: This waiver will serve children, from birth through age 17, who meet the ICF/MR level of care. These children, due to their behavioral needs, require the specialized services provided through this HCBS waiver in order to remain in or return to the family home. The critical goal of this waiver is to assure that children who are at risk of entering an ICF/MR, can live in the family home.

This waiver is intended to:

- preserve a family's capacity to care for their child;
- assure the health and safety of the child within the family

Organizational Structure: Seniors and People with Disabilities (SPD) is the division within the Single State Medicaid Agency, the Department of Human Services (DHS), that is responsible for managing and overseeing all programs to individuals with disabilities and seniors. SPD will operate this program directly. The Behavioral Waiver is administered by SPD employees housed within Children's Intensive In-home Services (CIIS) which operates all three model waivers. Centralizing the administration and oversight of the program will assure consistency and provide for skilled oversight, monitoring and case management services.

Service Delivery Methods:

Seniors and People with Disabilities contracts directly with the qualified providers chosen by the individuals and families through the family/person-centered planning process. Seniors and People with Disabilities staff will oversee the service plan development and assist individuals and families to choose their services providers.

## 3. Components of the Waiver Request

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**The waiver application consists of the following components.** *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

**E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

**F. Participant Rights.** **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

**G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

**H. Quality Improvement Strategy.** **Appendix H** contains the Quality Improvement Strategy for this waiver.

**I. Financial Accountability.** **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

**J. Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

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**A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

**B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

- Not Applicable**
- No**
- Yes**

**C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

- No**
- Yes**

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

*Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

#### 5. Assurances

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In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed

in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
In 1999, families with disabled children testified before the Legislature about the need for more services for children with disabilities who live in their family homes. The Legislature responded by increasing funding for CIIS. CIIS to continues to solicit input from families, advocacy organizations, provider agencies, community and government agencies and to integrate input from all sources, including those mentioned above.

\*add more information here about last session ....\*

**J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Oregon**

**Zip:**

**Phone:**  **Ext:**   **TTY**

**Fax:**

**E-mail:**

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

<b>Agency:</b>	<input type="text" value="Oregon Department of Human Services"/>		
<b>Address:</b>	<input type="text" value="500 Summer Street NE"/>		
<b>Address 2:</b>	<input type="text"/>		
<b>City:</b>	<input type="text" value="Salem"/>		
<b>State:</b>	<b>Oregon</b>		
<b>Zip:</b>	<input type="text" value="97301-1076"/>		
<b>Phone:</b>	<input type="text" value="(503) 945-6455"/>	<b>Ext:</b> <input type="text"/>	<input type="checkbox"/> <b>TTY</b>
<b>Fax:</b>	<input type="text" value="(503) 373-7274"/>		
<b>E-mail:</b>	<input type="text" value="don.h.fries@state.or.us"/>		

## 8. Authorizing Signature

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This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

<b>Signature:</b>	<input type="text" value="James Toews"/>		
	State Medicaid Director or Designee		
<b>Submission Date:</b>	<input type="text" value="Mar 13, 2009"/>		
<b>Last Name:</b>	<input type="text" value="Toews"/>		
<b>First Name:</b>	<input type="text" value="James"/>		
<b>Title:</b>	<input type="text" value="SPD Assistant Director"/>		
<b>Agency:</b>	<input type="text" value="Oregon Department of Human Services"/>		
<b>Address:</b>	<input type="text" value="500 Summer Street NE"/>		
<b>Address 2:</b>	<input type="text"/>		
<b>City:</b>	<input type="text"/>		

	<input type="text" value="Salem"/>
<b>State:</b>	<b>Oregon</b>
<b>Zip:</b>	<input type="text" value="97301"/>
<b>Phone:</b>	<input type="text" value="(503) 945-6478"/>
<b>Fax:</b>	<input type="text" value="(503) 373-7823"/>
<b>E-mail:</b>	<input type="text" value="james.d.toews@state.or.us"/>

### Attachment #1: Transition Plan

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Specify the transition plan for the waiver:

### Additional Needed Information (Optional)

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Provide additional needed information for the waiver (optional):

### Appendix A: Waiver Administration and Operation

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**1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

**Seniors and People With Disabilities (SPD)**

(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

**a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

a) SPD operates as a Division within the Oregon Department of Human Services (the Single State Medicaid Agency). SPD is responsible for the administration of services to persons who are aged (65+), and/or physically or developmentally disabled.

b) The Oregon Revised Statutes give clear authority to SPD serve the populations defined in (a) above.

c) Regular \*and ongoing\* discussions with Division Assistant Director and staff.

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

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**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) *(select one)*:

**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

**No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

## Appendix A: Waiver Administration and Operation

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**4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(Select One)*:

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

*Specify the nature of these agencies and complete items A-5 and A-6:*

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*Specify the nature of these entities and complete items A-5 and A-6:*

## Appendix A: Waiver Administration and Operation

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- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

## Appendix A: Waiver Administration and Operation

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- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

## Appendix A: Waiver Administration and Operation

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- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

*Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency
Participant waiver enrollment	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>

Function	Medicaid Agency
Level of care evaluation	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

#### a. Methods for Discovery: Administrative Authority

*The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.*

##### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

State Agency staff directly administer the services under this waiver.

\*Thus, this oversight requirement is automatically met.\*

#### b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

State Agency staff directly administer the services under this waiver.

\*Thus, this oversight requirement is automatically met.\*

##### ii. Remediation Data Aggregation

###### Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: See information in b.1.	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix B: Participant Access and Eligibility**

**B-1: Specification of the Waiver Target Group(s)**

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	0	17	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Mental Retardation	0	17	<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="radio"/> <b>Mental Illness</b>					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

**b. Additional Criteria.** The State further specifies its target group(s) as follows:

Children with significant behaviors who meet an initial score of 200 on the Behavioral Conditions Criteria and do not subsequently fall below a score of 150. Prior authorization is required for all services.

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

A minimum of six months prior to reaching the maximum age limit for enrollment in this waiver, individuals will be evaluated for services available under the Oregon Health Plan, Oregon’s other HCBS waivers serving adults (the Comprehensive Waiver and Support Services Waiver), or other programs. \*Based on this assessment, individuals who meet eligibility will be referred by the CIIS service coordinator to the programs most appropriate to meet their needs. CIIS will coordinate with the receiving agency to transition individuals into their new programs based on the prioritization process established in the Oregon Administrative Rules for these programs.\*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

**The limit specified by the State is (*select one*)**

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

*Specify:*

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based

services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.  
*Complete Items B-2-b and B-2-c.*

- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the State is (select one):**

- The following dollar amount:**

Specify dollar amount:

**The dollar amount (select one)**

- Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- The following percentage that is less than 100% of the institutional average:**

Specify percent:

- Other:**

*Specify:*

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (2 of 2)

**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**

**Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

**Other safeguard(s)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	143
Year 2	150
Year 3	160
Year 4	160
Year 5	160

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

- The State does not limit the number of participants that it serves at any point in time during a waiver year.
- The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	130
Year 2	135
Year 3	140
Year 4	145

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 5	150

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (2 of 4)

c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- Not applicable. The state does not reserve capacity.**
- The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served (3 of 4)

d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- The waiver is not subject to a phase-in or a phase-out schedule.**
- The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. **Allocation of Waiver Capacity.**

*Select one:*

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. **Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Children with significant behaviors who meet an initial score of 200 on the Behavior Conditions Criteria and do not subsequently fall below a score of 150. Prior authorization is required for all services.

Children who lose eligibility due to change of functional or residential status, or changes in child's income will be referred to other services or programs.

## Appendix B: Participant Access and Eligibility

### B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State  
 SSI Criteria State  
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No  
 Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

*Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)*

- Low income families with children as provided in §1931 of the Act  
 SSI recipients  
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121  
 Optional State supplement recipients  
 Optional categorically needy aged and/or disabled individuals who have income at:

*Select one:*

- 100% of the Federal poverty level (FPL)  
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)  
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)  
 Medically needy in 209(b) States (42 CFR §435.330)  
 Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)  
 Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

*Specify:*

All individuals deemed to be receiving SSI under Section 1634 and other relevant sections of the Social Security Act.

*Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- A special income level equal to:**

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- A dollar amount which is lower than 300%.**

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

- 100% of FPL**
- % of FPL, which is lower than 100%.**

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (select one):

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- Use spousal post-eligibility rules under §1924 of the Act.**  
(Complete Item B-5-b (SSI State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**  
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**  
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (2 of 4)

#### b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

##### i. Allowance for the needs of the waiver participant (*select one*):

- The following standard included under the State plan**

*Select one:*

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**

(*select one*):

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of the FBR, which is less than 300%**

Specify the percentage:

- A dollar amount which is less than 300%.**

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

*Specify:*

- The following dollar amount**

Specify dollar amount:  If this amount changes, this item will be revised.

- The following formula is used to determine the needs allowance:**

*Specify:*

The maintenance needs allowance is equal to the individual's total income as determined under the post eligibility process which includes income that is placed in a Miller trust (income cap trust).

- Other**

*Specify:*

**ii. Allowance for the spouse only (select one):**

- Not Applicable (see instructions)**
- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount:  If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

*Specify:*

**iii. Allowance for the family (select one):**

- Not Applicable (see instructions)**
- AFDC need standard**
- Medically needy income standard**
- The following dollar amount:**

Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:**

*Specify:*

- Other**

*Specify:*

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges

- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State establishes the following reasonable limits**

Specify:

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (3 of 4)

#### c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-5: Post-Eligibility Treatment of Income (4 of 4)

#### d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

## Appendix B: Participant Access and Eligibility

### B-6: Evaluation/Reevaluation of Level of Care

*As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

- a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

#### i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. **Frequency of services.** The State requires (select one):

- The provision of waiver services at least monthly**
- Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

b. **Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency**
- By the operating agency specified in Appendix A**
- By an entity under contract with the Medicaid agency.**

*Specify the entity:*

- Other**  
*Specify:*

c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing the LOC evaluations are state Seniors and People with Disabilities staff trained to administer the instrument. All staff must meet the qualifications as established in the SPD position specifications that require:

- Bachelor's degree in Social work/Human Services or related field; OR
- Bachelor's degree in any field not closely related AND one year of human services related experience (i.e., work providing assistance to individuals and groups with issue such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate house). OR
- Three years of human services related experience (i.e., work providing assistance to individuals and groups with issues such as economically disadvantaged, employment, abuse and neglect, substance abuse, aging, disabilities, prevention, health, cultural competencies, inadequate housing).

d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

All individuals considered for this waiver must meet the ICF/MR LOC determined by the Title XIX Waiver Form. All individuals must be determined eligible for developmental disability services and additionally are assessed using the Behavioral Conditions Criteria checklist. This checklist combined with the Title XIX Waiver Form comprise the complete level of care evaluation for this waiver population. Individuals must receive a score of 200 or more on the Behavioral Conditions Criteria checklist to initially qualify for this waiver.

The Behavioral Conditions Criteria checklist scores various behavioral characteristics that impact the ability of the child to function at home and in the community. This instrument measures the frequency and intensity of behaviors that have persisted over the past six months.

The child must meet the following:

- Initially score 200 or greater as determined by the Behavioral Conditions Criteria checklist instrument;
- Maintain a score on the instrument of 150 or greater as re-evaluated every twelve months (children who fall below 150 will be transitioned off of the waiver within 6 months);
- Reside in the family home; and
- Be capable of being safely served in the family home within the limitations of applicable administrative rules.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

CIIS coordinators conduct an initial level of care eligibility review utilizing the Behavioral Conditions Criteria instrument. CIIS coordinators conduct the eligibility review in the family home on a face-to-face basis. The eligibility review includes interviews with the child, family members, and other professionals as appropriate. CIIS coordinators also review the child's records if available. The CIIS coordinators then communicate the Behavioral Conditions Criteria score to the family and/or referring party. An initial score of 200 or greater will qualify the child for the waiver.

\*On an annual basis thereafter, the CIIS coordinators conduct a face to face reevaluation for eligibility, which includes a review of pertinent service and medical records.\* Eligibility is maintained if the instrument score is 150 or greater. Children who fall below 150 are transitioned off of the waiver within 6 months.

g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months**
- Every six months**
- Every twelve months**
- Other schedule**

*Specify the other schedule:*

h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- The qualifications are different.**

*Specify the qualifications:*

i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The CIIS Program maintains a tickler system to remind CIIS coordinators that re-evaluations are due.

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

CIIS keeps the level of care documentation in each child's service record.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**
  - i. **Sub-Assurances:**

- a. **Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

**Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

The percentage of waiver applicants for whom CIIS staff have completed a level-of-care assessment (includes Behavioral criteria and T.XIX waiver forms) to determine ICF/MR LOC eligibility prior to enrollemt. Numerator = the number of applicants who have a completed level of care assessment. Denominator = the total number of applicants for CIIS waiver services.

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *CIIS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

The percentage of all waiver participants who have received a redetermination of ICF/MR level of care prior to the end of the twelfth month since their initial determination or last redetermination. Numerator: All participants with a level of care redetermination prior to the end of the twelfth month since their initial or last redetermination. Denominator: All waiver participants.

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *CIIS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response

		distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

c. *Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**The Percentage of Waiver participants whose waiver eligibility was determined using the appropriate processes and instruments according to the approved description. - Numerator: Waiver participants whose waiver eligibility was determined using the appropriate processes and instruments according to the approved description. - Denominator: All waiver participants**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: *CIIS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

CIIS management:

- completes file reviews quarterly;
- notifies CIIS coordinators of need (and timeline) for correction or further documentation using the QA review form;
- conducts administrative followup to review remediation of problems; and
- provides retraining as necessary.

CIIS staff enter file review data into a QI tracking spreadsheet of chart reviews, outcomes, and remediation.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- No  
 Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

--

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Parent(s), guardians, or legal representatives of children who are eligible for services under the waiver are informed by the CIIS Coordinators, during the assessment and eligibility process, of feasible alternatives for services and offered a choice as to which type of service to receive: waiver or institution. The Title XIX Waiver Form documents the offer of choice, and the choice made by the parent(s), guardian or legal representative.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

CIIS keeps the Title XIX waiver form in each child's service record.

## Appendix B: Participant Access and Eligibility

### B-8: Access to Services by Limited English Proficiency Persons

**Access to Services by Limited English Proficient Persons.** Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The need for translation services is identified by the CIIS coordinators at the time a child is initially referred for CIIS eligibility determination. CIIS coordinators make families aware of their right for translation services to access Medicaid services. DHS employs staff in both the central and local offices who can translate eligibility requirements, rights and responsibility requirements and assist families in obtaining a range of state and federal services. DHS also has a statewide contract that can be utilized when local resources are limited for interpreting and translation. CIIS bilingual coordinators assist families to receive appropriate translation services in state and local government offices, medical and counseling offices, community clinics, hospitals and nursing facilities according to Medicaid requirements.

Translation services for persons who are monolingual are offered through the CIIS solely for the purpose of safely implementing the plan of care between family, child and provider for those services delivered within the family home. Translation services are also included in the other two SPD model waivers for children (MFCU Hospital waiver and Medically Involved Nursing Facility waiver). The translation services paid with CIIS funds are beyond those provided to

Medicaid clients in Oregon through the typical office-based service delivery model. The purpose of translation services is to establish and maintain the same understanding of the child's care requirements between the private, in-home providers and the families who must work together to implement the plan of care.

CIIS coordinators access the DHS Translation Contract and statewide pool of translators. Utilization of services on the contract is charged to the CIIS accounting codes.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Homemaker/Chore		
Statutory Service	Respite		
Extended State Plan Service	Physical Therapy/Occupational Therapy/Speech and Language		
Other Service	Behavioral Consultant		
Other Service	Environmental Accessibility Adaptations		
Other Service	Family Training		
Other Service	Non-Medical Transportation		
Other Service	Special Diets		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Translation		

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Statutory Service

**Service:**

Homemaker

**Alternate Service Title (if any):**

Homemaker/Chore

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Services consisting of general housekeeping when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home or to allow the caregiver more time to care for the individual. Paying a homemaker allows the family members time to provide hands on skilled care. Housekeeping also includes services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access

and egress. Chore services are considered one-time or intermittent services and are not available on a routine basis.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Housekeeping services will not exceed 20 hours per month.

**Service Delivery Method** (*check each that applies*):

- Participant-directed as specified in Appendix E  
 Provider managed

**Specify whether the service may be provided by** (*check each that applies*):

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual Worker
Agency	Housekeeper/Chore Agencies

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**

**Service Name: Homemaker/Chore**

**Provider Category:**

Individual

**Provider Type:**

Individual Worker

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Pass Criminal Records Review - ORS 410.070, CIIS OAR 411-350-0080, 411-300-170

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS - verify tax ID

**Frequency of Verification:**

At initial authorization of services and bi-annually thereafter.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Statutory Service**

**Service Name: Homemaker/Chore**

**Provider Category:**

Agency

**Provider Type:**

Housekeeper/Chore Agencies

**Provider Qualifications****License** (*specify*):

Retail business license and tax I.D. number

**Certificate** (*specify*):
**Other Standard** (*specify*):

DHS/SPD CHILDREN'S INTENSIVE IN-HOME SERVICES - OAR 411-350-0050, 411-350-0080

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS verifies current license and tax I.D.

**Frequency of Verification:**

At initial authorization of services and bi-annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

**Service:**

**Alternate Service Title (if any):**


Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Services are provided to children on a periodic basis furnished because of the absence of or need for relief of the primary caregiver. Respite includes both day and overnight care. Respite care is not available to allow caregivers to attend school or work.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Respite care is not available as an 8 hour a day, five days a week service. Days of overnight camp use will be limited to 10 days per individual plan year.

CIIS does not pay room and board in any situation. If respite care is provided in a licensed site, payment will not include room and board. Respite care can be provided in the child's home or the provider's home.

This waiver does not provide services to children in Foster care.

**Service Delivery Method** (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Group Home
Individual	Individual Respite Provider
Agency	Foster Home
Agency	Disability-related or therapeutic recreational camps
Agency	Agency-operated Respite Program
Agency	Day Care Center

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


---

**Service Type: Statutory Service**

**Service Name: Respite**

---

**Provider Category:**

Agency 

**Provider Type:**

Group Home

**Provider Qualifications**

**License (specify):**

Licensed under OAR chapter 411, division 325 for 24-Hour Residential Programs.

**Certificate (specify):**




**Other Standard (specify):**



**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to Authorization of Service and bi-annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**


---

**Service Type: Statutory Service**

**Service Name: Respite**

---

**Provider Category:**

Individual 

**Provider Type:**

Individual Respite Provider

**Provider Qualifications**

**License (specify):**




**Certificate (specify):**

**Other Standard** (*specify*):

ORAR 407.007.0200 - DHS Criminal History Background rules.

ORAR 411.0350.0010 through 411.0350.0120 - DHS, SPD, CIIS rules.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization of services and bi-annually thereafter.

## Appendix C: Participant Services

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### C-1/C-3: Provider Specifications for Service

---

**Service Type:** Statutory Service

**Service Name:** Respite

---

**Provider Category:**

Agency

**Provider Type:**

Foster Home

**Provider Qualifications****License** (*specify*):

ORAR 411.050.400 to 0408 - Adult Foster Homes

**Certificate** (*specify*):

ORAR 411.346.0000 through 0230 - SPD Child Foster Homes, ORAR 413.200.0301 - Child Welfare Foster Home.

**Other Standard** (*specify*):
**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS - Verify License or certificate

**Frequency of Verification:**

Prior to authorization of service and bi-annually thereafter.

## Appendix C: Participant Services

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### C-1/C-3: Provider Specifications for Service

---

**Service Type:** Statutory Service

**Service Name:** Respite

---

**Provider Category:**

Agency

**Provider Type:**

Disability-related or therapeutic recreational camps

**Provider Qualifications****License** (*specify*):

ORAR 333.030 -DHS, Public Health Div-Organizational Camp Rules

**Certificate** (*specify*):
**Other Standard** (*specify*):

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization of service and bi-annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**Agency **Provider Type:**

Agency-operated Respite Program

**Provider Qualifications****License (specify):**

OAR 411.050.0400 to 0408 - Adult Foster Homes

**Certificate (specify):**

411.346.0100 to 0230 - SPD Child Foster Homes, OAR 413.200.0301 - Child Welfare Foster Homes

**Other Standard (specify):**

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS - Verify license or certificate

**Frequency of Verification:**

Prior authorization and bi-annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**Agency **Provider Type:**

Day Care Center

**Provider Qualifications****License (specify):**

OAR 414-300-000 to 410 - Employment Department Childcare Division

**Certificate (specify):**

**Other Standard (specify):**

ORS 657A.600 - Authority to license and certify daycare settings

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and bi-annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Extended State Plan Service

**Service Title:**

Physical Therapy/Occupational Therapy/Speech and Language

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

These services will be provided through the Oregon Health Plan (OHP) until the plan limitations have been reached. Waiver funds will be used for services exceeding those limitations.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

These services cannot be accessed until the State plan benefit has been exhausted. Only interventions and treatments that are commonly accepted practice are allowable. Experimental and unproven treatments are expressly excluded. There are very specific OHP limits on PT/OT/SL. For CIIS, this is an extended state plan service. If the Division of Medical Assistance Programs (DMAP), which administers the OHP, has denied further treatments, and the assessment by the professional and the services coordinator and physician is that the child would benefit by continued services, CIIS will authorize these visits in the home or in a clinic. Physician orders and the therapist's plan must accompany the authorization request.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Speech and Language
Agency	Speech and Language
Agency	Occupational Therapy
Individual	Physical Therapy
Individual	Occupational Therapy
Agency	Physical Therapy

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Physical Therapy/Occupational Therapy/Speech and Language****Provider Category:**

Individual

**Provider Type:**

Speech and Language

**Provider Qualifications****License (specify):**

ORS 681.250 through 681.991

**Certificate (specify):****Other Standard (specify):**

ORS 681.250 through 681.991

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment and annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Physical Therapy/Occupational Therapy/Speech and Language****Provider Category:**

Agency

**Provider Type:**

Speech and Language

**Provider Qualifications****License (specify):**

ORS 681.250 through 681.991

**Certificate (specify):****Other Standard (specify):**

ORS 681.250 through 681.991

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS


**Frequency of Verification:**

Prior to authorization and payment and bi-annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service**

**Service Name: Physical Therapy/Occupational Therapy/Speech and Language**

---

**Provider Category:**Agency **Provider Type:**

Occupational Therapy

**Provider Qualifications****License (specify):**

ORS 675.210 through 675.340

**Certificate (specify):****Other Standard (specify):**

OAR Chapter 339 - Occupational Therapist Licensing Board Procedural Rules.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment and bi-annually thereafter.

**Appendix C: Participant Services**

---

**C-1/C-3: Provider Specifications for Service**

---

**Service Type: Extended State Plan Service****Service Name: Physical Therapy/Occupational Therapy/Speech and Language**

---

**Provider Category:**Individual **Provider Type:**

Physical Therapy

**Provider Qualifications****License (specify):**

ORS 688.020 - 688.230

**Certificate (specify):****Other Standard (specify):**

OAR Chapter 848 - Physical Therapy Licensing Board Policies and Rules.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment and annually thereafter.

**Appendix C: Participant Services**

---

**C-1/C-3: Provider Specifications for Service**

---

**Service Type: Extended State Plan Service****Service Name: Physical Therapy/Occupational Therapy/Speech and Language**

---

**Provider Category:**Individual **Provider Type:**

Occupational Therapy

**Provider Qualifications**

**License (specify):**

ORS 675.210 through 675.340

**Certificate (specify):**

**Other Standard (specify):**

OAR Chapter 339 - Occupational Therapist Licensing Board Procedural Rules.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment and bi-annually thereafter.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Extended State Plan Service****Service Name: Physical Therapy/Occupational Therapy/Speech and Language****Provider Category:**

Agency

**Provider Type:**

Physical Therapy

**Provider Qualifications****License (specify):**

ORS 688.020 - 688.230

**Certificate (specify):**

**Other Standard (specify):**

OAR Chapter 848 - Physical Therapy Licensing Board Policies and Rules.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment and annually thereafter

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Behavioral Consultant

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Behavior consultation consists of: A written assessment of the child, the needs of the family, and the environment including consultation with other professionals; Development of a written positive behavior support plan to address specific behaviors; training of family and providers to implement the positive behavior support plan; and, periodic monitoring and revision of the written positive behavior support plan as needed.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Behavior consultation does not include: mental health therapy or counseling; health or mental health plan coverage; direct in-home care; educational (school) services, including, but not limited to, consultation and training for classroom staff, adaptations to meet needs of the individual at school, or any service identified by the school as required to carry out the person's Individual Education Plan or otherwise covered under the Oregon Health Plan. This does not duplicate family training.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E
- Provider managed

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Agencies providing behavioral consultation services
Individual	Individual behavioral consultation practitioners

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Behavioral Consultant****Provider Category:**

Agency

**Provider Type:**

Agencies providing behavioral consultation services

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

OAR 411.300.0170(2) and personal and professional references.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment and bi-annually thereafter.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type:** Other Service  
**Service Name:** Behaviorial Consultant

**Provider Category:**

Individual

**Provider Type:**

Individual behavioral consultation practitioners

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

OAD 411-300-0170(2) and personal and professional references; OAD 407.007.0200, DHS criminal History Background Check.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to Authorization and Payment and bi-annually thereafter.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Environmental Accessibility Adaptations

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Adaptations may include, but are not limited to, the installation of ramps and grab-bars, adaptations of doorways, handrails, adaptations of kitchen cabinets/sinks, modification of bathroom facilities, individual room air conditioners to maintain stable temperature as required by the individual's behavioral condition, installation

of non-skid surfaces, or installation of specialized electric and plumbing systems which are necessary to accommodate the behavioral characteristics of the individual, hardening of walls, floors, windows. Environmental modification consultation necessary to evaluate the family home and make plans to modify the home to ensure the health, welfare and safety of child is included.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation. For home adaptations that exceed \$5,000 the Department will protect its interest through liens or other legally available means. Home adaptations that are provided in a rental structure must be authorized in writing by the owner of the structure prior to initiation of the work.

**Service Delivery Method** (*check each that applies*):

- Participant-directed as specified in Appendix E**  
 **Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

- Legally Responsible Person**  
 **Relative**  
 **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Building Contractor
Individual	Consultant

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations**

**Provider Category:**

Individual

**Provider Type:**

Building Contractor

**Provider Qualifications**

**License** (*specify*):

Building Contractor - Licensed Contractor under OAR 812-001-0000 through 812-010-0500 and 808-001-0000 through 808-005-0030.

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS and SPD Housing Specialists.

**Frequency of Verification:**

Prior to authorization of service and payment for each modification request.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations**

**Provider Category:**

Individual

**Provider Type:**

Consultant

**Provider Qualifications**

**License (specify):**

Licensed contractors under OAR 812-001-0000 through 812-010-0500 and 808-001-0000 through 808-005-0030.

**Certificate (specify):**

**Other Standard (specify):**

Environmental modification consultants must be a licensed general contractor and have experience evaluating family homes to make the home safe and accessible for the child. The contractor must also be approved by the SPD Housing Specialist.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS and SPD Housing Specialists.

**Frequency of Verification:**

Prior to authorization of service and payment for each modification request.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Family Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Family Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home; training of the family or relatives to increase the individual's capabilities, to care and maintain the child in the family home; information, education, training and materials about the child's disability, medical and health conditions to increase the

family's capability to care for their family member including attendance at conferences or group training; family counseling to relieve the stress associated with caring for an individual with disabilities.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

"Family" does not include individual family members who are employed to care for the client. Payment of registration fees for conferences or workshops will be made only where the family members will obtain information or skills that will enable them to better care for their child. Room and board and transportation are not paid for. Services otherwise available under the Oregon Health Plan are not covered under family training. Family training does not duplicate the Behavior Consultant or Specialized Medical Equipment training. Family training is for conferences or other educational settings. Family training can also be provided by an MSW or psychologist to assist the family or parent with the stresses of having a child with a disability. Family training is not a behavior consultant who comes into the home to assess the child, develop a plan and train the caregivers on the needs and behaviors of the child.

**Service Delivery Method** (check each that applies):

- Participant-directed as specified in Appendix E**  
 **Provider managed**

**Specify whether the service may be provided by** (check each that applies):

- Legally Responsible Person**  
 **Relative**  
 **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Licensed psychologists, Social worker, Counselor, Health educator, Individual Trainers
Agency	Local, state, or national organizations or educational entities that provide training

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**  
**Service Name: Family Training**

**Provider Category:**

Individual ▾

**Provider Type:**

Licensed psychologists, Social worker, Counselor, Health educator, Individual Trainers

**Provider Qualifications**

**License** (specify):

ORS 675.210 through 675.340 licensing, definitions and enforcement.

**Certificate** (specify):

Trainers: Oregon Intervention System Certificate

**Other Standard** (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS Staff or DMAP

**Frequency of Verification:**

Prior to authorization and payment.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**  
**Service Name: Family Training**

**Provider Category:**

Agency

**Provider Type:**

Local, state, or national organizations or educational entities that provide training

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Training content must be related to the child's disability - personal and professional references.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment for each family training request.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Non-Medical Transportation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care.

\*This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them.

Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge will be utilized.\*

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

The plan of care sets the parameters and limits for this service on an individual basis. Transportation to and from school is not included in this service. Mileage is reimbursed at the current DHS-approved transportation rate.

**Service Delivery Method** (*check each that applies*):

- Participant-directed as specified in Appendix E**  
 **Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

- Legally Responsible Person**  
 **Relative**  
 **Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Local Transportation Authorities
Individual	Direct Services Worker

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

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**Service Type: Other Service**  
**Service Name: Non-Medical Transportation**

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**Provider Category:**

Agency

**Provider Type:**

Local Transportation Authorities

**Provider Qualifications**

**License** (*specify*):

Per Oregon's standards for public transportation.

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization for service and payment.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

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**Service Type: Other Service**  
**Service Name: Non-Medical Transportation**

---

**Provider Category:**

Individual

**Provider Type:**

Direct Services Worker

**Provider Qualifications**

**License** (*specify*):

Driver's license

**Certificate** (*specify*):

**Other Standard** (*specify*):

Individuals providing transportation must also have a valid driver's license and proof of insurance and be a qualified CIIS provider per OAR 411.300.0055 and 411.350.0070 \*which includes criminal history background and child abuse registry clearance.\*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment with each request.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Special Diets

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Special diets: includes, depending upon an individual's medical condition or diagnosis, specially prepared food and/or particular types of food needed to sustain the individual in the family home. Special diets can include high caloric supplements, diabetic, ketogenic, gluten/casein-free (does not include vitamins). Special diets must be ordered by a physician and periodically monitored by a dietician. Special diets will not constitute a full nutritional regime.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Special diets and dietician services otherwise available under the Oregon Health Plan are not covered. Special diets are not based on the culinary abilities of the family. Therefore, restaurant and prepared foods are not included.

**Service Delivery Method** (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Vendor
Individual	Dietician

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Special Diets**

**Provider Category:**

Agency

**Provider Type:**

Vendor

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Tax I.D. as a business.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization of service needs.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Other Service**  
**Service Name: Special Diets**

**Provider Category:**

Individual

**Provider Type:**

Dietician

**Provider Qualifications**

**License (specify):**

OAR 834-001-0000 through 834-010-0065.

**Certificate (specify):**

**Other Standard (specify):**

Special diets shall be ordered by a physician and periodically monitored as by a dietitian. Special diets shall not constitute a full nutritional regime.

Services must be provided as per OAR 411-350-0050, OAR 411-350-0070 and OAR 410-141-0280, Division of Medical Assistance Programs - Oregon Health Plan.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Periodic monitoring by a dietitian.

**Frequency of Verification:**

Prior to authorization and payment and bi-annually thereafter.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Specialized Medical Equipment and Supplies

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Specialized medical equipment and supplies to include devices, aids, controls, supplies, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform or access activities of daily living, or to perceive, control, or communicate with the environment in which they live. When a professional is required to identify or adapt the equipment, this can be paid for as part of the purchase of the equipment. Coverage may include the performance of assessments to identify the type of equipment needed. When a professional is required to identify or fit equipment, CIIS will include this cost in the purchase price of the equipment.

This service also includes items and training necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Examples include: sensory equipment; incontinence devices or items; communication devices; positioning devices; purchase of mobility devices related to behaviors; latex gloves; the increased utility costs (over general household use) associated with obsessive/compulsive and increased waste related to incontinence; specially designed clothing to meet the unique needs of the child with a disability. This service may include adaptation of the family vehicle to meet the unique needs of the individual.

All items shall meet applicable standards of manufacture, design and installation.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

Items paid with waiver funds shall be in addition to any equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual.

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Vendors
Agency	Medical and Rehabilitative Supply Companies

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment and Supplies****Provider Category:**

Agency

**Provider Type:**

Vendors

**Provider Qualifications****License (specify):**

For supplies only: have a retail business license.

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications****Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization of service and payment.

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Specialized Medical Equipment and Supplies****Provider Category:**

Agency

**Provider Type:**

Medical and Rehabilitative Supply Companies

**Provider Qualifications****License (specify):**

For supplies only: companies have a retail business license.

**Certificate (specify):**

**Other Standard (specify):**

For medical equipment: an enrolled Medicaid Provider through the Division of Medical Assistance Program. OAR 410.411.0280 Division of Medical Assistance Programs Oregon Health Plan.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS and DMAP

**Frequency of Verification:**

Prior to authorization of service and payment.

**Appendix C: Participant Services****C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Translation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

**Service Definition (Scope):**

Translation services provided in the family home necessary for the family to communicate with direct care providers about the delivery of services outlined in the plan of care and directly related to the health of the child. These are translation services are not part of the eligibility determination process and are above and beyond those that are typically available to Medicaid clients through the Oregon Health Plan. These services are necessary to ensure that the plan of care is successfully implemented in the family home.

**Specify applicable (if any) limits on the amount, frequency, or duration of this service:**

N/A

**Service Delivery Method (check each that applies):**

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by (check each that applies):**

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Translation Service Agency
Individual	Individual Translator
Individual	Health Care Interpreters

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Translation**

**Provider Category:**

Agency

**Provider Type:**

Translation Service Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

OAR 333.002- Public Health Division Certification and Qualification fo Health Care Interpreters.

**Other Standard (specify):**

OAR 407.005 DHS Client Rights; OAR 411.300.150, CIIS; OAR 410.411.0280; Department of Human services qualified list of translators and interpreters.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**

**Service Name: Translation**

**Provider Category:**

Individual

**Provider Type:**

Individual Translator

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

OAR 407-005 DHS Client Rights; OAR 411-300-150, CIIS; OAR 410-411-0280; Department of Human Services list of qualified translators and interpreters.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior to authorization and payment.

## Appendix C: Participant Services

### C-1/C-3: Provider Specifications for Service

**Service Type: Other Service**  
**Service Name: Translation**

**Provider Category:**

Individual

**Provider Type:**

Health Care Interpreters

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

OR 333.002 - Public Health Division Certification and Qualification of Health care Interpreters.

**Other Standard (specify):**

OR 407.005 - DHS Clients Rights; OR 411.300.150, CIIS; OR 410.411.0280; DHS list of qualified translators.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

CIIS

**Frequency of Verification:**

Prior authorization of each services and payment.

## Appendix C: Participant Services

### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All in-home care providers, licensed and unlicensed are subjected to a criminal history review. A State of Oregon background check is done on all personal assistants, attendants, housekeepers, nurses, therapists, and consultants. All potential providers are screened against the DHS Child Welfare abuse and neglect registry. If there is a child abuse or neglect finding, CIIS contacts the applicable child welfare office for further information prior to making a final determination. If there is a criminal history of concern or the provider has lived outside of the state of Oregon in the last 3 years, a national fingerprint check will be completed. Every criminal history is reviewed by the DHS Criminal Records Unit and reviewed by CIIS for final determination. No provider receives a provider number for payment of services until a criminal record check and related child abuse background check have been completed and the person is cleared to work.

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The state maintains databases of individuals against whom there has been a finding of child abuse or neglect. CIIS references the State of Oregon Child Abuse registry for anyone applying to be a direct care provider for a child as part of the criminal history check. The Oregon Child Abuse database is maintained by the DHS Child Welfare office. Prospective employers can contact the Office of Investigation and Training within DHS to check any prospective employee against the database of individuals who have had a finding of abuse or neglect of a child with disabilities in a residential facility.

\*Oregon Child Care Division within the Department of Employment licenses, certifies or registers all day care providers based on the size and type of the day care. The requirements include a criminal history and child abuse registry background check for all day care employees. CIIS coordinators and administration inform camps of the requirements for criminal history record background checks and the expectation to keep results of such check on file as a condition of providing service for CIIS children and payment by CIIS.\*

(b) \*CIIS conducts a review of the Oregon child abuse registry for all providers of intensive in-home services. CIIS accepts a provider's current license or certificate in lieu of a child abuse registry check when the license or certificate is issued by a state agency that requires abuse registry clearance as part of licensing or certification process.\*

(c) CIIS administrative staff review the results of all background checks and informs the prospective provider if they have cleared the process. If the provider has cleared, the CIIS coordinator and family are informed and the hiring process may begin.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.**

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

CIIS does not pay parents, legal guardians or other legally responsible adults for services. Oregon can pay qualified providers who are grandparents, siblings aged 18 and over, aunts, uncles, etc. for respite, housekeeping services, community transportation, and home modifications (if they are a licensed contractor). When the relative is trained and skilled in providing the service and the family requests to hire them, and the relative passes the criminal background check, CIIS will pay the relative to provide the services specified in the plan of care. Payments are made based on the plan of care, prior authorization, CIIS coordinator review of timesheets, including the signature of the parent and provider verifying that services were rendered as authorized. If there is a limitation on the amount of services that relatives may furnish, it is contained in the plan of care. Often the sibling or grandparent has been involved in the child's care for years. If the choice is between hiring a total stranger, training them, and bringing them into the family home, or using someone who is

qualified and trusted by the family, the family/individual has the option to choose the person they know and trust.

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Oregon provides extensive Web-based and paper materials (including forms in Spanish) for the enrollment of providers. Materials and information about Children's Intensive In-home Services provider enrollment is readily available on the Oregon DHS website. Parents advertise for providers in a variety of ways to include the newspaper, the internet and via posted signs in public places. Anyone who requests a provider enrollment packet receives one.

The Department of Human Services and the Division of Seniors and People with Disabilities make provider enrollment materials available to any individual agency or organization that wishes to become a provider. Families may, with the assistance of the CIIS coordinator, advertise for providers through a variety of media, including the Internet. There is continuous, open enrollment of providers. A potential provider may apply for enrollment at any time.

SPD and CIIS make every effort to enroll providers within two weeks once the application is complete and all background checks are completed. A provider agreement will be executed with any provider who meets qualifications.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

#### a. Methods for Discovery: Qualified Providers

##### i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

##### Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

##### Performance Measure:

The percentage of providers requiring licensure and/or certification who are initially and continually qualified per Oregon administrative rules. - Numerator: Providers that, prior to providing waiver services, initially met and continue to meet qualification requirements - Denominator: All Providers.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**The percentage of non-licensed/non-certified providers who adhere to waiver and Oregon Administrative Rule requirements. - Numerator: Non-licensed/non-certified providers that adhere to provider qualifications described in this waiver. - Denominator: All non-licensed/non-certified providers.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group:

		<input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**The percentage of providers who are trained per Oregon administrative rules and the approved waiver. - Numerator: Providers that are trained per Oregon administrative rules and the approved waiver. - Denominator: All Providers.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
	Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

CIIS staff learn of problems from multiple sources, including file reviews, client interviews, observation in the family home, and reports from families, community partners, and other professionals. CIIS staff check the status of provider licenses initially and, at minimum, every two years to verify qualifications. Criminal histories are completed on a schedule consistent with Oregon Administrative rules.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

When CIIS Staff learn of problems, they contact the provider immediately, ask for further information, and assign an appropriate time for correction.

CIIS staff follow up with providers to ensure corrections are made.

If issues are not remediated in a timely manner, CIIS removes the provider authorization to provide waiver services.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No**
- Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix C: Participant Services

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### C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

## Appendix C: Participant Services

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### C-4: Additional Limits on Amount of Waiver Services

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

- Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix D: Participant-Centered Planning and Service Delivery

---

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**

Comprehensive Plan of Care

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**  
 **Licensed practical or vocational nurse, acting within the scope of practice under State law**  
 **Licensed physician (M.D. or D.O)**  
 **Case Manager** (qualifications specified in Appendix C-1/C-3)  
 **Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

Bachelor's degree in business or public administration, Behavioral or social sciences, or a degree related to the agency program that demonstrates the capacity for the knowledge and skills; and two year's experience coordinating or administering a program; OR

Any combination of experience or education equivalent to five year's of experience that typically supports the knowledge and skills requirements listed for the classification in the areas of communication and the medical and social needs of children with disabilities.

- Social Worker.**

*Specify qualifications:*

- Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

- b. **Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**  
 **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (3 of 8)

- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) At the time of the initial service plan development meeting, CIIS coordinators make families aware of all the potential programs and resources for which they may be eligible, including the Oregon Health Plan. CIIS coordinators provide information and assistance to individuals to understand the range of services available and assist the individual and/or family to select options that meet the individual's needs. Coordinators provide this information through discussions with individuals and families but also direct individuals and families to Web resources, printed materials, and other agencies.

b) OAR 411.350.0040, regarding the Comprehensive Plan of Care, requires that the CIIS coordinators prepare the plan of care with the family input and with the input of any other individuals the family wishes to be part of the planning process.

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **D-1: Service Plan Development (4 of 8)**

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) Who develops the plan, who participates in the process, and what is the timing of the plan?

Within 45 days of program eligibility determination, the CIIS coordinator develops the plan of care face-to-face with the individual/parent/legal representative in the family home at a time that is convenient for the family. Other persons, as requested by the individual/family/legal rep, may also contribute to this plan. Each plan includes the type of service to be provided, the amount, frequency and duration of each service, the type of provider to furnish each service and the person responsible for carrying out the service. The plan of care is an ongoing document and evolves over time as the individual's needs change and the family and CIIS Coordinator have the opportunity to research various options.

(b) What types of assessments are conducted to support the service plan development process, including information about individual's needs, preferences and goals, and health status?

The assessment of each child's needs includes: a face-to-face interview and observation in the family home to assess the individual's functional abilities, strengths in completing activities of daily living, identification of risks related to health and safety; the CIIS Behavioral Criteria; existing assessments and plans obtained from other programs; information from medical care providers. Assessment includes psycho-social elements and the availability of natural supports. Coordinators assist in the development of the family's response plans for natural disasters or other emergencies.

(c) How is the participant informed of services available under the waiver?

CIIS coordinators inform individuals/family/legal representatives verbally and in writing about service options during plan development and in the event of changes in the individual's condition. Once service needs have been recorded and summarized, the individual/parent/legal representative have another opportunity to review the services authorized and delivered and what types of supports are needed to meet the plan of care goals.

(d) How does the plan development process ensure that the service plan addresses participant goals, needs (including health care needs), and preferences?

Based on the needs assessment and discussion with the family, MFCU coordinators incorporate the family's identified needs, stated goals, and preferences in the plan of care. The family and individual choose their services and how they will be provided consistent with the plan.

(e) How are waiver and other services coordinated?

As the plan is implemented, CIIS coordinators communicate with individuals/family and providers as needed in order to oversee the coordination of services. CIIS coordinators contact involved parties by phone, mail, e-mail, fax or in person in the home and in planning meetings to address service delivery issues. CIIS coordinators assure service delivery through ongoing observation and communication to identify and solve potential service delivery and service coordination problems. CIIS coordinators identify existing social networks or natural supports (such as friends and family) and non-Medicaid community programs, services and resources (such as services under IDEA or local recreation programs) and work with the family to integrate applicable supports into the plan of care.

(f) How does the plan development process provide for the assignment of responsibilities to implement and monitor the plan?

The plan of care assigns responsibility for implementation of all service elements. The CIIS coordinator has the responsibility to monitor the implementation.

(g) How and when is the plan updated, including when the individual's needs change?

The CIIS coordinator follows the waiver and Oregon Administrative Rules that require that the service plan be updated face-to-face at least every 365 days and more frequently based on continuous monitoring of an individual's condition or living situation.

This monitoring includes direct contact with family and providers to ensure that services are based on current needs. The individual/family has the right to request a reassessment or update of the plan of care at any time.

The waiver and rule requirements are part of CIIS coordinator training, their ongoing performance evaluations, and waiver quality assurance activities.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **D-1: Service Plan Development (5 of 8)**

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

During initial plan of care development and subsequent reviews, the CIIS coordinator makes observations and on-going assessments of risk factors for health, safety and protection with the child and family/legal representative. The CIIS coordinator offers resources and works with the child and family to plan appropriate services, including nursing, nursing delegation, respite, and other in-home supports. DHS/SPD conducts criminal history and abuse background checks on all providers. The CIIS coordinator monitors all service delivery and payments and is a mandatory reporter of child abuse, neglect and Medicaid fraud. Families and children may also report abuse.

When the plan calls for nursing delegation, the RN develops a nursing care plan for the child and family/legal representative and provider to follow, delegates nursing tasks to the provider, and establishes a monitoring schedule. Nursing delegation consists of training, delegated tasks and monitoring which must conform to Oregon Board of Nursing standards. Physicians must sign all nursing care plans. Nurses must document delivery of services and report any concerns to the physician and CIIS coordinator. In addition, the nurse must report any child protection concerns directly to law enforcement or the local child welfare office.

When the plan of care includes personal care services and/or respite, SPD/DHS acts as fiduciary agent on behalf of the parent who is the employer of record. CIIS coordinators assist with locating providers and supply each family and individual provider with written materials explaining the program, how to develop job descriptions, and program rules for payments, billing, etc. With guidance from CIIS coordinators, family/legal representatives interview, hire, schedule, and oversee all personal care and respite providers. Parents or legal representatives of children served on this waiver may temporarily act as a backup when no paid assistance is available.

CIIS coordinators assist families in developing emergency procedures and backup plans for each plan of care. Since children served on the CIIS Model Waivers live in the family home, the family is responsible for the child's care when providers are unavailable. CIIS coordinators assist in locating service providers and in developing a backup plan, but cannot impose a specific provider or backup plan on the family. CIIS Coordinators and families discuss emergency plans, including plans that address absence of scheduled paid providers and other potential crises. CIIS coordinators assist the family to identify family members and potential providers who can act as backup. CIIS coordinators continually assist families that have difficulties finding and keeping providers through support with advertising and contacting community resources. Examples of options discussed with families include: using an in-home provider agency rather than an individual, out-of-home respite, and recruiting through the local Lifespan respite program. If the family uses an in-home provider agency, the agency is responsible to seek provider backup.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **D-1: Service Plan Development (6 of 8)**

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

\*CIIS coordinators provide education to families about service provider options initially at enrollment, at annual re-evaluation and ongoing as indicated by family need.\* Families are given verbal and written information about how to advertise, interview and select providers. The process is family-directed. CIIS coordinators assist the family to contact the local provider referral resources such as human services programs, residential agencies, Lifespan respite (the statewide respite recruitment, information and referral source for respite). Each child, who has the ability to participate, is involved in all aspects of their service plan development and service delivery. CIIS coordinators refer the children and their families to local Community Developmental Disability Program (CDDP) offices for current lists of individuals and agencies who are already qualified to perform the services needed. Families may also recruit and interview individual service providers. DHS completes background check requirements and confirms valid license or certificates prior to parents making the hiring decision and CIIS making payment. The state is the fiscal intermediary and issues the W-2's and 1099's.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Seniors and People with Disabilities is a Division within the Department of Human Services, which is the Single State Medicaid Agency. CIIS coordinators who approve the plans of care are employees of Seniors and People with Disabilities.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

*Specify the other schedule:*

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) \*The CIIS coordinator is responsible for monitoring the implementation of the service plan and for providing oversight of health and safety of CIIS services. The CIIS coordinator visits each family home at least annually and more frequently based on the coordinator assessment of need or family request. CIIS supervisory staff review plans and make visits, as necessary or upon request, to family homes to assure the service plan has been implemented as written. Supervisory home visits are made when training new CIIS coordinators, sampling coordinator performance and responding to specifically identified need regarding waiver services.\*

(b) The CIIS coordinator monitors services through observing the provision of services, reviewing provider records and other documentation of service delivery including billing records, case notes, and discussions with families/legal representatives.

Services coordinators evaluate the effectiveness of services against the goals and objectives specified in the plan of care and work with the family to modify the plan as needed.

When monitoring, the CIIS coordinator reviews, discusses and addresses the following:

- participant's free choice of provider,
- effectiveness of emergency plans and need for backup,
- participant health and welfare, and
- participant access to non-waiver services in service plan.

The CIIS coordinator visits the family home, observes the child in the family home, observes the provider working in the family home, reviews the service plan at least annually, and has regular ongoing contact with the family by phone and e-mail.

(c) The CIIS coordinator is required to meet face-to-face with the family or individual at least every six months. The CIIS coordinator makes phone or e-mail contact at least every 60 days with the family or service providers to monitor the implementation of the plan.

The CIIS coordinator works with the family and provider to immediately address any concerns that are identified.

The CIIS coordinator monitors adherence to service plans and Oregon Administrative Rules on a regular basis.

- b. Monitoring Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **Quality Improvement: Service Plan**

*As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.*

- a. Methods for Discovery: Service Plan Assurance/Sub-assurances**  
**i. Sub-Assurances:**

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

#### **Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**The percentage of all participant's service plans that address assessed needs and personal goals. - Numerator: All participant's service plans address assessed needs and personal goals - Denominator: All participant service plans.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *CHS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b>	

Specify: <input style="width: 100%; height: 20px;" type="text"/>
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

**\*Percentage of service plans that appropriately reflect needs identified by the Behavioral Conditions Criteria. Numerator: Number of service plans that appropriately reflect needs identified by the Behavioral Conditions Criteria. Denominator: All service plans.\***

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b>

		Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *CIIS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**The Percentage of service plans that are developed in accordance with CIIS rules, policies and procedures - Numerator: Plans that are developed in accordance with CIIS rules, policies and procedures - Denominator: All Plans**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: *MFCU uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a

		response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

\*Percentage of service plans that are developed with the family, signed by the parent, and received by the parent. Numerator: Number of service plans developed with the family, signed by the parent, and received by the parent. Denominator: All service plans.\*

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *CHS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

**Performance Measures**

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

**Performance Measure:**

**The percentage of service plans that are updated or revised annually -**

**Numerator: Plans that are renewed within 365 days of the previous plan or revised when participant needs change - Denominator: All Plans**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *MFCU uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10%

		margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

The percentage of service plans that are revised when warranted by a change in needs. - Numerator: Service plans that are revised when revised when participant needs change - Denominator: All Service plans

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b>

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *MFCU uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

- d. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

**Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**The Percentage of Services delivered in accordance with what is specified in the service plan including the type, scope, duration and frequency. - Numerator:** Service Plans for which services delivered are in accordance with the type, scope, duration and frequency specified in the plan - **Denominator:** All service plans

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b>

		Specify: Random sample of over 50% of population.
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

\*The percentage of plans where expenditures are consistent with assessed needs.

**Numerator:** Number of plans where expenditures are consistent with assessed needs. **Denominator:** All plans.\*

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *MFCU uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

**Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

**The percentage of participants who are offered choice of between waiver and institutional care. - Numerator: Waiver forms that indicate the Participant was offered choice between waiver and institutional care. - Denominator: All waiver forms**

**Data Source (Select one):**

**Financial records (including expenditures)**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: Random sample of over 50% of population.
	<input type="checkbox"/> Other Specify:	

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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

The percentage of participants who are offered choice of waiver services and providers  
**Numerator:** Participants who are offered choice of waiver services and providers  
**Denominator:** All participants

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>

	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Random sample of over 50% of population.
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis ( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

CIIS management:

- completes file reviews quarterly;
- notifies service coordinators of need (and timeline) for correction or further documentation using the QA review form;
- conducts administrative followup to review remediation of problems; and
- provides retraining as necessary.

CIIS staff enter file review data into a QI tracking spreadsheet of chart reviews, outcomes, and remediation.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- No**  
 **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

**Applicability** *(from Application Section 3, Components of the Waiver Request):*

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.  
 **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** *(select one):*

- Yes. The State requests that this waiver be considered for Independence Plus designation.**  
 **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Participants for the model waiver include the child, the parent(s) and/or the legal guardian. The participants are informed as to their ability and responsibility to direct the services of the program from the very first meeting when the child is found eligible by the CIIS coordinator. This is an ongoing process throughout the entire time the child is eligible for this waiver.

(a) Participants are asked initially what services they require to remain in the family home and their preferences. Based on the parameters of the program, both state plan services and waiver services, a plan is developed taking into account what is needed in relation to the child's disability, the child's and family's preferences, and what is allowable under the waiver and rule. Services can be redirected throughout the entire life of the plan, either as needed or annually, depending on what the participant requests.

(b) Participants may call, write, e-mail or fax their services coordinator to discuss the services in place and make changes or additional requests to the plan. Participants have many opportunities to change or fine tune the plan based on changing needs and physical abilities. Again, this can be done during the annual review or when the family feels it is needed.

(c) The CIIS coordinators, based upon their experience and their observation of the child's needs and the family situation, can make service recommendations to the child and family. CIIS coordinators provide education and direction about the program, to include how the program works and services that can be provided to help the participant make choices that keep the child healthy and safe.

(d) Participants are continually encouraged to make choices and direct the care for the child. They choose the providers they want to work with their child; they review, verify accuracy and sign the timesheets and payment vouchers; and they hire, train and fire providers. When possible, the child has input into their plan and choice of providers. The family and participant is encouraged to report any substandard, dangerous or abusive behaviors regarding service delivered. The participant chooses which waived services are important to the child and family. They work with their health care providers to determine and guide the level of care the child receives. They schedule their providers and other persons who come into the home to work with their child. Participant direction is reflected in every service provided by this program. They select the waived services they feel will keep their child, or themselves (if the child), healthy and safe and supported in the home. They also select the amount of the services within the overall plan.

## Appendix E: Participant Direction of Services

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### E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. **Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

### E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

## Appendix E: Participant Direction of Services

### E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) All participants (child, parents, and/or legal guardian) are provided information about participant directed opportunities at the initial face-to-face meeting in the family home. CIIS coordinators review with the participant all aspects of the program and provide them with a family information manual of materials that includes program rules, and information on how to find, interview, hire and train providers. This includes how to write a job description, schedule staff, and employer liabilities. The CIIS coordinator reviews with the family how providers are enrolled, the criminal history and abuse background check process, how people are approved for work, and how providers are paid. Roles and responsibilities of all parties are discussed including potential liabilities to the family regarding employment of a provider to work in the family home. The plan is developed with the participant, reviewing the waived services available based on the child's disability and the related issues identified by the participant. The CIIS coordinator reviews the information again during the next few meetings and when the plan of care is developed and signed. The participant can contact the CIIS coordinator to clarify the information any time they have questions.

b) CIIS staff are continuously available to furnish program information face-to-face, via phone, e-mail or mail to

new or ongoing participants.

c) This information is provided during the initial meeting after eligibility has been determined, during development of the initial plan of care, during the annual review and at any time information is requested by the participant. CIIS staff may provide additional information as necessary.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Family Training	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Physical Therapy/Occupational Therapy/Speech and Language	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Translation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Special Diets	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Non-Medical Transportation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Behavioral Consultant	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input checked="" type="checkbox"/>	<input type="checkbox"/>

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities**
- Private entities**

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**  
*Do not complete Item E-1-i.*

**Appendix E: Participant Direction of Services**

**E-1: Overview (8 of 13)**

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

**Answers provided in Appendix E-1-h indicate that you do not need to complete this section.**

**Appendix E: Participant Direction of Services**

**E-1: Overview (9 of 13)**

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies):*

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Family Training	<input type="checkbox"/>
Homemaker/Chore	<input type="checkbox"/>
Physical Therapy/Occupational Therapy/Speech and Language	<input type="checkbox"/>
Environmental Accessibility Adaptations	<input type="checkbox"/>
Translation	<input type="checkbox"/>
Special Diets	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Behavioral Consultant	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

a) CIIS coordinators furnish these supports.

b) Supports are provided by a variety of methods. In-home care and respite providers are paid through MMIS. Waivered services are paid by a variety of methods, always either directly procured by the CIIS coordinator or requested and authorized by the CIIS coordinator. The service is delivered to the child's home after payment has been made, in most cases. If it is a capital expenditure or specifically fitted item, payment is through a purchase order with payment occurring after the item fits the child and the participant is satisfied with the service. Families receive no money from the State to pay for these services. All payments are made by DHS. CIIS coordinators have credit cards to purchase or pay for services. Checks and purchase orders are used when it is not possible to use a credit card. Contracts are written by the SPD housing program for home modifications and capital improvements.

c) The family is given the opportunity, information and direct assistance they need in order to direct all aspects of the plan of care. All parts of the waiver are participant driven. If the participant chooses to use respite, they select and hire the respite provider. If they choose housekeeping, they select and hire a housekeeper. For supplies and services, they choose from an array of services available, the CIIS coordinator will assist participants in finding the most cost effective method of fulfilling their request. If a home modification is requested, the CIIS coordinator works with the participant and SPD housing program to develop a plan based on the child's disability and best practices. Families get bids for housing projects, CIIS or the SPD housing program helps find contractors if the family is unable to locate at least two bids on a project.

d & e) The CIIS supervisor reviews all requests for home modifications and works closely with the CIIS coordinator and the SPD housing program. The supervisor reviews all credit card purchases monthly, looking at the credit card statement, the purchasing log, receipts and care plans for consistency and appropriateness. All requests from participants are prior approved by the supervisor based on the child's disability. The supervisor signs all requests for checks and purchase orders.

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

#### k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

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### E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

If the participant chooses to terminate their involvement with the CIIS, they can do that in a variety of ways.

As this is a voluntary program, the participant can choose to terminate all involvement with the CIIS program. The participant can inform CIIS in writing stating that they no longer want these services. The CIIS coordinator discusses alternative service options and terminates the waiver as requested. CIIS contacts local service agencies and makes referrals according to the family's wishes. When CIIS terminates the CIIS waiver at age 18 and the participant remains in their own home, the participant may be eligible for the Support Services, Comprehensive Services or Aged and Physically Disabled waivers.

When a child can no longer be maintained in the family home due to circumstances in the family, the parent may choose placement rather than remaining enrolled in the CIIS waiver. The CIIS coordinator works with the family and County DD services coordinator to help with the transition. The participant is informed of the process to open a crisis case plan and the need to work with the County DD services coordinator or Child, Adult and Family Services to begin the process of looking at possible placements. CIIS services remain in place during the transition. The CIIS coordinator continues working with the family until an actual out of home placement is completed. The CIIS coordinator is available throughout the process to assist with the transition for all parties involved. This includes visiting placement resources with the participant at their request. The waiver is terminated by the CIIS coordinator when the child enters a long-term out of home placement.

## Appendix E: Participant Direction of Services

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### E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the child is removed from the home by Child Welfare Services due to abuse and neglect issues, the CIIS waiver is terminated. When Child Protective Services removes a child from the family home, Child Welfare Services takes on the assurance of health and welfare for this child including responsibility to establish reunification plans. If not, Child Protective Services coordinates with the local developmental disability program to identify an appropriate SPD-licensed placement resource for the child. When the child re-enters DD services, the child is enrolled in the Comprehensive Services Waiver when SPD assumes responsibility for the child. If the child is not MR/DD, Child Welfare retains responsibility for the case. If the family is able to re-unify, the family can reapply for CIIS services.

## Appendix E: Participant Direction of Services

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### E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
Waiver Year	Number of Participants	Number of Participants	
Year 1	140		
Year 2	150		
Year 3	160		
Year 4	160		
Year 5	160		

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**  
 **Refer staff to agency for hiring (co-employer)**  
 **Select staff from worker registry**  
 **Hire staff common law employer**  
 **Verify staff qualifications**  
 **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**  
 **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**  
 **Determine staff wages and benefits subject to State limits**

- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

Participants work with DHS to ensure that all federal and State of Oregon employment laws are followed.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

- b. Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

- i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

- b. Participant - Budget Authority**

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including

how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

- iii. Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

- iv. Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

#### b. Participant - Budget Authority

**Answers provided in Appendix E-1-b indicate that you do not need to complete this section.**

- v. Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Seniors and People with Disabilities has standardized forms and processes for informing individuals/legal representatives of rights, recording hearing requests, completing pre-hearing summaries, conducting hearings, and notifying individuals/legal representatives of the hearing outcomes. \*Notice is given to the individual if an adverse action is made regarding choice of HCBS vs. institutional services and choice of providers.\*

When CIIS enrolls an individual on the waiver, the parent or legal guardian is given a copy of their fair hearing rights, form SDS 0948. This is reviewed with them and they are asked to sign form SDS 0949 (signature page indicating receipt). They are given a copy. This process is repeated yearly when the plan of care is updated or whenever there is any planned change in services or benefits, including denial, closure or reduction.

Per OAR 411.300.0210, individuals, their parents or legal representatives are provided timely written notice (on Seniors and People with Disabilities form SDS 0947 - Notice of Planned Action) of any planned change in services or benefits, including denial, closure or reduction. The notice includes the reason for DHS's decision, rules that support the decision and the individual/legal representative's right to due process through an administrative hearing, and their right to continue current service levels during the appeal process. There is a box on the request for hearing form that individuals or parent/legal guardian can check requesting services to continue during the appeal process.

Individuals/legal representatives who wish to contest the planned action must complete and submit an Administrative Hearings Request (Seniors and People with Disabilities form 443) to the central office address listed on the hearing request form. CIIS forwards the Administrative Hearings Request to the Seniors and People with Disabilities Central Hearings Unit where it is assigned to a DHS Hearing Representative. The Hearing Representatives are centralized and not part of any local office that determines benefits, services, or eligibility. The Hearing Representative reviews the notice sent to the participant to confirm adequacy and accuracy.\*

The Hearing Representative conducts an informal conference with the individual/legal representative to provide the individual/legal representative the opportunity to question the planned action and to present additional information if applicable. After the informal conference, one of four actions occur:

- The individual/legal representative voluntarily withdraws the request for hearing;
- DHS withdraws the planned action;
- The planned action is modified (in which case a new notice of planned action is sent to the individual/legal representative and the individual/legal representative once again has appeal rights); or
- The contested case proceeds to hearing before an Administrative Law Judge.

If the individual/legal representative disagrees with the outcome of the fair hearing as determined by an Administrative Law Judge, the individual/legal representative may ask for an administrative review or reconsideration of the final order. The individual/legal representative may also file with the Court of Appeals. Seniors and People with Disabilities maintains an automated database that tracks each phase of the process and the outcomes(s) for each individual/legal representative who requests an administrative hearing. Copies of all notices and findings, whether favorable or adverse, are maintained in each child's record.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

**a. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**a. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

Anyone may file a grievance/complaint about waiver services with the Governor's Advocacy Office in the Office of the Director of the Department of Human Services, or may file with any DHS or County DD staff member. The Seniors and People with Disabilities Division has the responsibility to respond to any complaints about its services in accordance with timelines satted within the Oregon Administrative rules.

**b. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

There is no limitation on the types of complaints an individual may file.

\*People may complain directly to CIIS, SPD or to the Governor's Advocacy Office (GAO) within the Department of Human Services. All or grievances about CIIS are logged into a statewide tracking system that includes the date and nature of the complaint and the date and nature of the resolution. If the complaint comes through the GAO, advocacy office staff contact SPD or CIIS is contacted to research and help resolve the complaint.\*

CIIS complaint and or grievance procedures:

1. Every parent is given a copy of their rights when the individual is originally enrolled and yearly afterwards with the renewal of the Plan of Care. This includes their right to make a complaint or appeal a decision, and their right to a Medicaid fair hearing, and a description of the process and timelines. The family is told that filing a grievance/complaint is not a pre-requisite or substitute for a fair hearing.
2. CIIS attempts to solve all complaints and grievances in an informal manner through mediation with the manager and service coordinator within 30 days.
3. If the client/parent registers a complaint by phone, the call is directed to the manager for review. The CIIS manager either speaks to the person or responds to voicemails with a follow-up call or a response in writing. If it is a

telephone call, the outcome is recorded, summarized in a letter or note with the summary to the complainant and a copy to the individual's record. If the complaint is sent via e-mail, the response is in writing with a copy sent to complainant and a copy to the individual's record.

4. If the complainant chooses a formal grievance process, they can use form SDS 0946 and put the grievance/complaint in writing. This is not required; telephone and e-mail complaints are accepted. The written grievance/complaint is reviewed by the manager with input from the service coordinator. The response will be in writing and mailed to the complainant via certified mail, with a copy included in the client record.

5. If the complainant is not satisfied with the response they receive from the CIIS manager, they may request an administrative review. This must be in writing with the reason they are requesting it. This will be reviewed by members of the SPD administrative review team, with input from the CIIS manager and service coordinator if appropriate. The response will be in writing.

6. If SPD determines that the complaint or grievance is hearable, the participant can file a fair hearings request.

7. All complaints, grievances, administrative reviews and hearing requests and outcomes are recorded.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

CIIS coordinators and service providers are mandatory reporters of child neglect and abuse. Individuals that are required to report are defined in ORS 419.005 and ORS 430.765. Medicaid service providers for this waiver are informed of their mandatory abuse reporting responsibility upon their enrollment as a provider. Parents are informed that the CIIS coordinators and the service providers are mandatory reporters. Reports of child abuse and neglect are made primarily by phone, immediately upon suspecting that abuse or neglect has occurred or upon a known threat of harm. Reports are made directly to local law enforcement or to the child protective service office in the county where the child resides. \*The state of Oregon has a cross-reporting statute for suspected child abuse that applies to DHS and law enforcement entities. The statute requires DHS child welfare and law enforcement to cross report to each other within specified time frames based on assessed level of risk.\* The parent and provider handbooks describe the mandatory reporting responsibilities and how to report suspected child abuse and neglect.

CIIS coordinators are also mandatory reporters of Medicaid fraud. Parents and providers are informed of this through the CIIS parent and provider handbooks. Reports of suspected fraud are made immediately to the DHS Fraud Unit. Should investigations occur as a result of a report of abuse or fraud, CIIS coordinators cooperate with the investigation and incorporate recommendations into any subsequent service plans of care.

All CIIS coordinators are required to report critical events and incidents and make reports of suspected abuse and neglect across all types of SPD services. Critical incidents are defined in OAR 411.320.0020(2) and (68). Reporting can be done in a variety of media and is required immediately or within five days of the event, depending on the type and nature of the incident and the type of service provided.

SPD maintains a secure, Web based system, Serious Event Reporting and Tracking (SERT), for identification and

follow up tracking of critical events. Service coordinators enter critical or unusual incidents into SERT. Critical or unusual incidents are defined as serious illness or accidents, death of an individual, injury requiring inpatient or emergency medical care, non-routine emergency room care, suicide attempts, psychiatric hospitalization, emergencies where police, fire or ambulance must respond, criminal referrals to the police, abuse or neglect reports requiring investigation, or other critical events determined on a per individual or per service basis. Local and state Quality Assurance staff review critical incidents and related follow up data on a monthly basis to identify emerging trends. State and local SERT teams made up of Service Coordinators, Program Specialists, Quality Assurance specialists and Administrators, convene at least quarterly to develop local and system-wide responses and preventive actions to address system deficiencies or emerging themes that could potentially harm individuals served.

All children enrolled in the CIIS Behavioral waiver live in their family home where the waiver services are delivered. The parents or their legal guardians are ultimately responsible for the care and safety of the child. All of the children eligible for the CIIS Waiver have significant behavioral support needs. Even though CIIS coordinators oversee the appropriateness and safety of the CIIS services, the CIIS coordinators may not be notified by the family or service provider of each critical incident listed above. CIIS coordinators for the CIIS waiver will record all known critical or unusual incidents with corresponding follow up activity in the case note section of individual's case record. CIIS coordinators will track all Child Welfare and Law Enforcement reports and investigations and reports of fraud/financial exploitation on a separate working log titled "CIIS Clients Referred to Child Welfare or Law Enforcement Agency". The log will include the current date, the recipient's name, the recipient's medical ID number, the type of issue (abuse, neglect, potential criminal referral, Medicaid fraud) reported, date reported, outcome, date the outcome was finalized, and name of assigned service coordinator. This log will provide the basic protective service information for entry in SERT. In addition, CIIS coordinators for this waiver will enter all reports of deaths, and suicide attempts into SERT. CIIS management and administrative staff participate on the statewide SERT Team to review data and determine if emerging trends and geographic indicators overlap with other service elements and assure coordination of response and training initiatives if indicated.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

\*Information on abuse and neglect, including how and where to make report of abuse or fraud, is provided verbally and in writing to each family, legal guardian and provider by the CIIS coordinator at the time of enrollment, annual at plan renewal and ongoing during plan implementation based on need and family request.\* When the initial plan of care is developed with the family, the CIIS coordinator provides direct, face to face training and information about waiver services and reporting abuse, neglect and exploitation.

DHS maintains extensive Web and printed materials on how to report abuse and neglect of children. Information on how to report abuse and neglect can be found at: <http://www.oregon.gov/DHS/children/abuse/cps/report.shtml>.

Information on mandatory reporting of abuse, Medicaid Fraud and about child abuse in general is included in the CIIS parent and provider handbooks that are given to every family and provider at enrollment. Families are informed by their CIIS coordinators that all service coordinators and Medicaid providers are mandatory reporters of suspected abuse and neglect. Families and providers are encouraged through regular phone contact and direct visits to communicate concerns with their CIIS coordinator whenever concerns arise.

All CIIS employees are mandatory reporters of child abuse and neglect and are required to attend the DHS training on mandatory reporting. CIIS provides training material on abuse reporting to CIIS service providers and all providers receive a copy of the rule that states mandatory reporting requirements.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

\*Allegations of child abuse and neglect are reported by any concerned party to local child protective services offices (DHS Child Welfare) and /or to local law enforcement in the county or jurisdiction where the child lives. All reports of suspected child abuse and neglect are cross-reported according to statute between DHS and law enforcement. DHS Child Welfare and law enforcement are the only entities with the statutory authority to investigate allegations of child abuse and neglect. All processes and time frames, including the methods and timelines for cross reporting allegations, are defined in statute and DHS administrative rule.\* Investigations occur if, after initial screening, the allegation is determined to meet the statutory threshold of abuse, neglect or threat of

harm. Investigations are assigned either the same day or within 7 days depending on the nature of the allegation, whether an injury is present or a child is at immediate risk. The length of time for an investigation is 30 days after the investigation is assigned. Extensions for periods of 30 additional days per extension may be approved by the investigator's manager depending on complexity of the allegation and availability for interviews. Most investigations are completed within 60 days. Child protective service investigators typically interview family members, including all children, and make contact with other agencies involved with a family that is under investigation. CIIS coordinators assist with information about the child's disabilities and functioning level, the family situation and SPD services as requested by the investigator. Child protective services, depending on the nature and outcome of the investigation, may involve CIIS coordinators in developing recommendations and determining follow up actions, though it is not a requirement in statute and rule. Child protective services or law enforcement inform the family of the outcome of the investigation. CIIS coordinators assist families in meeting the recommendations through supports and activities such as modifying the service plan and providing additional training for family members.

Reports of suspected fraud are made by CIIS staff directly to the DHS Medicaid Fraud Unit or the DHS Provider Fraud Unit, depending on the allegation. Any concerned party may report fraud to CIIS or to the DHS Fraud Units. CIIS coordinators inform families and providers if CIIS makes a report of suspected fraud. \*Incidents of suspected fraud that could endanger a child and also be suspected child abuse are reported by the CIIS coordinator to DHS Child Welfare.\* Investigations occur by DHS staff employed in one of those Units. The DHS Fraud Unit informs the subject and CIIS of the outcome of the investigation. CIIS staff supply information, cooperate with the investigation and implement the recommendations from the investigations through activities such as modifying oversight of claims and revocation of provider status. There are no limits on the time frames for fraud investigations.

Critical events entered into the SERT system (described in G-1-b) that are not directly related to protective services or client or provider fraud are also included in the ongoing monitoring responsibilities of the CIIS coordinator and the general oversight of the CIIS waivers. Reports and entries of critical and unusual incidents are based on CIIS coordinator observation and information from families and providers. CIIS coordinators determine in consultation with the family and medical providers what specific follow up is needed, including how follow up will be provided and who will provide what activity. In addition to the review of each known incident by the CIIS coordinator, entries in the SERT system are reviewed on a monthly basis by CIIS coordinators, management and administrators to identify emerging trends for specific clients, families or the overall program. Action or corrective response is identified at both the individual service plan and the program level. CIIS coordinators work with families to modify service plans or provide additional resources or training to address specific emerging trends. Program policy and information to individuals and providers are addressed if programmatic needs are identified. CIIS management and administrative staff participate monthly on the SPD statewide SERT and Waiver Oversight groups to determine if emerging CIIS trends and potential responses overlap with other SPD service elements, geographic indicators or training initiatives in order to assure a coordinated agency response.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS Child Welfare is responsible to oversee all reporting, investigation and response to child abuse and neglect for all of Oregon's children.

DHS Child Welfare trains Child Protective Service (CPS) investigators and keeps an electronic and paper record of all allegations, investigations of abuse and the outcome, including the dates of reports, dates of investigations, dates of findings, nature of findings and notification of outcome.

CIIS notify families and providers of their responsibility as mandatory reporters and how to make reports of child abuse and neglect. Training materials are provided by CIIS upon entry into the program or enrollment as a provider.

DHS has the responsibility to oversee the response to critical incidents or unusual events for children in CIIS whether or not the events lead to an allegation of abuse or neglect. CIIS staff keep a log on reports of abuse and neglect and fraud and make entries into the SERT system as described in G-1-b and G-1-c. All critical events entered into the SERT system are reviewed on a monthly basis for emerging trends and patterns of concern and to determine what response is needed for CIIS and system wide.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

**a. Use of Restraints or Seclusion.** *(Select one):*

- The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

The children enrolled in the Behavioral (ICF/MR) Model Waiver are served in their family home. Their Plans of Care do not include the use of restraints or seclusion. CIIS coordinators who oversee the Plans of Care and the services delivered in the home report any use of restraints or seclusion through the SERT system. If harm is caused or there is a threat of harm, a report of child abuse is made to DHS Child Welfare or local law enforcement. CIIS coordinators, through monthly contact by phone, e-mail and visit with families and providers, perform continual service monitoring and guidance to families about the child's care and safety needs and appropriate service provision.

- The use of restraints or seclusion is permitted during the course of the delivery of waiver services.**  
Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

**b. Use of Restrictive Interventions.** *(Select one):*

- The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The children enrolled in the CIIS are served in their family home. Their Plans of Care do not include the use of restrictive interventions or seclusion. CIIS coordinators who oversee the Plans of Care and the services delivered in the home report any use of restraints or seclusion through the SERT system. If harm is caused or there is a threat of harm, a report of child abuse is made to DHS Child Welfare or local law enforcement. CIIS coordinators, through bi-monthly contacts by phone, e-mail or visitation with families and providers, perform continual service monitoring and guidance to families about the child's care and safety needs and appropriate service provision.

- The use of restrictive interventions is permitted during the course of the delivery of waiver services**  
Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

- a. Applicability.** Select one:

- No. This Appendix is not applicable** (*do not complete the remaining items*)
- Yes. This Appendix applies** (*complete the remaining items*)

- a. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Children on the CIIS waiver live and are served in their family home. The child's family and medical providers are directly responsible for medication management. The child's family works with the child's physician and other medical providers regarding the child's medications and medication management, including appropriate medication, dose, frequency, route, storage, side effects and interactions with other medications. The CIIS coordinator discusses medications, including suggestions for appropriate management and safety, with the family during the development and review of the plan of care and during regular monitoring activities. Through visits to the home, phone and e-mail contact with families and service providers, the CIIS coordinator determines if concerns exist regarding medication practices. The CIIS coordinator views medication administration records during home visits as part of general oversight of the CIIS service.

If CIIS pays for in-home nursing services, the nurses are responsible to administer medication during the time they are on shift and according to the physician's order. This expectation is part of the Plan of Care and the job description. The RNs, LPNs and CNAs are governed by Oregon Board of Nursing (OBN) rules (OAR 851.001.0000 through 851.063.0110) for all aspects of medication management. Their responsibilities include reporting medication irregularities to the OBN and to SPD, the authorizer of the Medicaid payment for their service. CIIS coordinators maintain regular contact with nurses who work in the family homes. Nurses call and e-mail the CIIS coordinators about the status of the child. All providers paid with SPD funds (nurses, aides and other in home providers) who administer medications to the CIIS child, follow the physician's orders and document medication administration on the form supplied by CIIS. As part of the CIIS coordinator's training for families, family members are encouraged to document medication administration on the same form, but it is not required. If there is a complaint regarding a potentially harmful medication practice from any source (family, paid provider or the medical community), CIIS staff and all providers exercise their responsibility as mandatory reporters of child abuse and neglect.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Services on the CIIS waiver are delivered to children in their family home. Families work with their child's medical providers regarding prescribed medications and medication management as described in G-2-b-i. CIIS coordinators maintain monthly contact with families or their in-home providers to oversee the services, including medication management. Contact consists of progress updates and discussion of status through phone and e-mail. Contact also consists of visits at least twice a year to the family home to review physician's orders, documentation and to see the child and the environment. This ongoing contact is documented in the child's CIIS record. The Plan of Care is reviewed and updated through direct face to face contact in the home at least annually and more frequently if the child's needs change. During their regular monitoring contact, CIIS coordinators are responsible to identify potential harmful practices, including medication practices, and to address them with the family, the in-home providers and with the child's medical providers. CIIS coordinators follow up on all known harmful practices by providing or arranging for education or training for families and non-licensed providers in medication management. CIIS coordinators also notify the prescribing physician if further follow up is needed and report to the OBN if licensed providers are in violation of their rules. Matters or practices that potentially rise to the level of a serious incident or child abuse or neglect are entered into the SERT system and reported immediately to DHS Child Welfare for an assessment of overall child safety within the family home and potential DHS Child Welfare action.

## **Appendix G: Participant Safeguards**

### **Appendix G-3: Medication Management and Administration (2 of 2)**

#### **c. Medication Administration by Waiver Providers**

##### **i. Provider Administration of Medications.** *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- i. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Licensed providers including RNs, LPNs and CNAs are governed by the Oregon Board of Nursing licensing OARs for all aspects of medication administration. All medications must be administered according to the orders of the prescribing physician. Physician's orders must be available within the home of the CIIS child as part of the Plan of Care. Non-medical or unlicensed providers of waiver services must administer medications under the direction of the family, according to orders of the prescribing physician and must document the medications as described in G-2-b-i & ii. Medication administration practices can be taught by the child's physician, the physician's office nursing staff, the delegating RN if one works in the home or by the family who has hired the unlicensed provider. CIIS coordinators can assist in general training regarding proper medication administration, documentation, and medication safety in the home. The family and any licensed nursing staff who work in the home are responsible to assure on a daily basis that medications are administered as ordered and taught. The requirements to administer medication according to the physician's order and to document medications are included in provider job descriptions. Children enrolled in the CIIS generally do not self-administer their medications.

- ii. Medication Error Reporting.** *Select one of the following:*

● **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

Medication errors are reported to the Oregon Board of Nursing if there are consistent concerns or serious incidents regarding errors made by licensed nursing personnel. Medication errors are also reported to the family, the child's physician and to the CIIS coordinators, depending on who or what type of provider is administering the medications. Medication errors, where reporting is required, are those errors that are serious and that could cause harm to the child. CIIS coordinators educate families and providers during ongoing contact on the importance of documenting medication administration, and on the importance of reporting medication irregularities. If CIIS coordinators learn of medication errors by the family, CIIS will notify the prescribing physician and child welfare if the child is endangered. CIIS coordinators also discuss provider performance to identify areas of concern and assist families in addressing concerns.

(b) Specify the types of medication errors that providers are required to *record*:

Licensed providers are required to record all medication errors on the medication administration record; wrong medication, missed medication, wrong time and wrong dose or route. Families and non-licensed providers employed by the family are trained to document the same information. Serious medication errors that could cause harm to the child must be recorded and reported by any party who becomes aware of the error.

(c) Specify the types of medication errors that providers must *report* to the State:

Serious medication errors that could cause harm to the child must be reported to CIIS, to the child's physician, to the child's parent or guardian and to the OBN or child protective services as indicated.

● **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

**iii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

CIIS is ultimately responsible to monitor the performance of providers regarding medication administration to children in the Behavioral waiver. CIIS coordinators must be sensitive to the fact that services to children in the Behavioral waiver are delivered in their family home where parents are in charge of their child's daily care and responsible for their child's safety in the home. CIIS coordinators develop continuous communication with families and providers to assure a steady flow of feedback about service delivery. Monitoring and corrective response activities performed by the CIIS coordinators take place monthly through phone, e-mail and face to face contact and include the following, at a minimum: communication with the child's medical professionals to assist with monitoring medication management in the home; contact with the family or their providers as described in G-2 to discuss the quality and satisfaction with delivered services and to provide opportunity to identify areas of concern; assistance to families with activities such as training and scheduling to improve performance of both licensed and unlicensed providers; review all of the nursing logs, medication records and notes for each child. CIIS reports concerns about licensed providers immediately to the Oregon Board of Nursing. Concerns can also be reported directly by families. Families are instructed by the CIIS coordinator and in the CIIS parent handbook about their rights as an employer, including how they can terminate a provider, make a complaint about a provider, and report potential abuse or neglect.

Critical incidents or serious events regarding medication practices are reported and tracked through the SERT system or reported to DHS Child Welfare if they meet the definition of suspected child abuse or

neglect. CIIS coordinators, management and administration review all SERT entries and abuse logs on a monthly basis as described in G-1 to identify themes and respond to concerning trends.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

#### a. Methods for Discovery: Health and Welfare

*The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.*

##### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**The percentage of participants who experienced substantiated abuse, neglect or exploitation. - Numerator: Participants who experienced substantiated abuse, neglect or exploitation) - Denominator: All participants of this waiver**

Data Source (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> <b>Other</b> Specify:	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

**\*QIS Percentage of participants who receive information on abuse and neglect, including where and how to report at minimum annually. Numerator: Number of participants who receive information on abuse and neglect, including where and how to report at minimum annually. Denominator: All participants.\***

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =
<input type="checkbox"/> <b>Other</b>	<input checked="" type="checkbox"/> Annually	

Specify: <input type="text"/>		<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *CIIS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

\*Percentage of complaints received from each type of referral source. Numerator: number of complaints received from each type of referral source. Denominator: total number of complaints received.\*

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: *CIIS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="text"/>	
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**\*Percentage of complaint issues addressed by the process and timelines identified in Oregon Administrative Rule. Numerator: number of complaint issues addressed by the process and timelines identified in Oregon Administrative Rule. Denominator: all complaints related to the Behavioral Model Waiver.\***

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *CIIS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response

		distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
 CIIS coordinators for the CIIS waiver record all known critical or unusual incidents with corresponding follow up activity in the case note section of individual's case record. CIIS coordinators track all Child Welfare and Law Enforcement reports and investigations and reports of fraud/financial exploitation on a separate working log titled “CIIS Clients Referred to Child Welfare or Law Enforcement Agency”. The log includes the current date, the recipient’s name, the recipient’s medical ID number, the type of issue (abuse, neglect, potential criminal referral, Medicaid fraud) reported, date reported, outcome, date the outcome was finalized, and name of assigned service coordinator.  
 Investigations occur if, after initial screening, the allegation is determined to meet the statutory threshold of abuse, neglect or threat of harm. Investigations are assigned either the same day or within 7 days depending on the nature of the allegation, whether an injury is present or a child is at immediate risk. The length of time for an investigation is 30 days after the investigation is assigned. Extensions for periods of 30 additional days per extension may be approved by the investigator’s manager depending on complexity of the allegation and availability for interviews. Most investigations are completed within 60 days. Child protective service investigators typically interview family members, including all children, and make contact with other agencies involved with a family that is under investigation. CIIS coordinators assist with information about the child’s disabilities and functioning level, the family situation and SPD services as requested by the investigator. Child protective services, depending on the nature and outcome of the

investigation, may involve CIIS coordinators in developing recommendations and determining follow up actions, though it is not a requirement in statute and rule. Child protective services or law enforcement inform the family of the outcome of the investigation. CIIS coordinators assist families in meeting the recommendations through supports and activities such as modifying the service plan and providing additional training for family members.

Reports of suspected fraud are made by CIIS staff directly to the DHS Medicaid Fraud Unit or the DHS Provider Fraud Unit, depending on the allegation. Any concerned party may report fraud to CIIS or to the DHS Fraud Units. CIIS coordinators inform families and providers if CIIS makes a report of suspected fraud. Investigations occur by DHS staff employed in one of those Units. The DHS Fraud Unit informs the subject and CIIS of the outcome of the investigation. CIIS staff supply information, cooperate with the investigation and implement the recommendations from the investigations through activities such as modifying oversight of claims and revocation of provider status. There are no limits on the time frames for fraud investigations.

Critical events entered into the SERT system (described in G-1-b) that are not directly related to protective services or client or provider fraud are also included in the ongoing monitoring responsibilities of the CIIS coordinator and the general oversight of the CIIS waivers. Reports and entries of critical and unusual incidents are based on CIIS coordinator observation and information from families and providers. CIIS coordinators determine in consultation with the family and medical providers what specific follow up is needed, including how follow up will be provided and who will provide what activity. In addition to the review of each known incident by the CIIS coordinator, entries in the SERT system are reviewed on a monthly basis by CIIS coordinators, management and administrators to identify emerging trends for specific clients, families or the overall program. Action or corrective response is identified at both the individual service plan and the program level. CIIS coordinators work with families to modify service plans or provide additional resources or training to address specific emerging trends. Program policy and information to individuals and providers are addressed if programmatic needs are identified. CIIS management and administrative staff participate monthly on the SPD statewide SERT and Waiver Oversight groups to determine if emerging CIIS trends and potential responses overlap with other SPD service elements, geographic indicators or training initiatives in order to assure a coordinated agency response.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix H: Quality Improvement Strategy (1 of 2)

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

## Appendix H: Quality Improvement Strategy (2 of 2)

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### H-1: Systems Improvement

### a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

SPD has operated this model waiver for children since 2001. The Division has tracked and analyzed information and developed system responses related to quality of care provided to waiver participants.

SPD staff are responsible for effectively utilizing the discovery and remediation information identified during the course of each year. Quality assurance and waiver staff from the Federal Resource and Financial Eligibility Unit work with CIIS staff to collect and analyze data and recommend programmatic changes for quality improvement.

CIIS management use the following data systems in aggregating information related to QA and QI:

- Level of care and plan of care tickler and tracking spreadsheets
- “CIIS clients referred to Child welfare or law enforcement agency” forms
- Contested Case Hearing Database
- Credit card QA checklist
- Children’s Developmental Disability Program Database for:
  - o Demographics
  - o Provider Information
  - o Purchases information

CIIS management or delegated staff attend and participate in monthly Developmental Disabilities Waiver Oversight (WO) meetings. These meetings are attended by DHS and SPD staff from a range of program and service areas including Licensing and Quality of Care, Office of Investigation and Training (OIT), County Relations, Adult Support Services, State Operated Community Programs and SPD Management. \*This group presents, compares, and discusses issues and trends in data reports across all waivers from a range of sources including OIT, Licensing, file and program reviews and surveys, County and State program QA meeting notes and summaries.\* Information and resources from other state programs and external sources is frequently shared and discussed.

CIIS staff attend and participate in quarterly Developmental Disabilities Quality Assurance Committee (DD-QAC). The DD-QAC is comprised of representatives from State program staff, SPD management, Provider organizations, Support Service Brokerages, County DD staff, Advocacy and Self-advocacy groups and the Oregon Technical Assistance Corporation. State program staff present regular Waiver program updates including enrollment data \*across all services and waivers\*, QA activities and report on benchmarks and progress towards QA and QI goals. DD-QAC participants advise State program staff on priorities and activities to further QA and QI goals.

\*CIIS utilizes reports from file reviews, enrollment data, and complaint log data to assess progress toward quality improvement goals and to establish new goals. CIIS collaborates with the Developmental Disabilities Council, Parents as Partners and the Families and Communities Together (FACT) to incorporate consumer feedback into long range service planning and program design.\*

CIIS staff also participate in the bi-annual QA Coordinator meetings where local QA trends and processes are identified and reviewed for local response. Though local processes often do not have direct bearing on CIIS model waivers, some trends may require coordinated responses.

As changes and improvements are made to other waiver programs, particularly the other two model waivers, these are evaluated for applicability and incorporated into the CIIS program as appropriate. In addition to the meetings noted above, CIIS staff receive and provide ongoing input and feedback in settings including weekly Developmental Disabilities Strategy meetings, biweekly Children’s In-Home Programs (all staff from the three Children’s model waiver) meetings, Administrative Rule workgroups and issue-specific cross-waiver workgroups.

### ii. System Improvement Activities

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Quality Improvement Committee</b>	<input checked="" type="checkbox"/> <b>Annually</b>

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

## b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

SPD staff administer all services delivered through this model waiver.

SPD staff use findings from discovery and remediation activities related to the six assurances and other parameters to establish priorities for system improvement and evaluate the effectiveness of those improvements.

The staff seek input from participants, families, providers, and other interested parties/groups to find ways to deliver waiver services more effectively and efficiently and move the participant toward outcomes stated in approved plans of care.

SPD staff collect QI information from the performance measures related to the six assurances and other topic areas. They work with participants, families, providers, and others to address both concerns raised and improvement opportunities identified.

SPD has created a Quality Management Strategy (QMS) detailed in a matrix available at [http://www.oregon.gov/DHS/spd/qa/app\\_h\\_qa.pdf](http://www.oregon.gov/DHS/spd/qa/app_h_qa.pdf) that details activities, roles, responsibilities and timelines for Quality Improvement.

This QMS encompasses waivers serving three populations: Seniors, adults with physical disabilities and individuals of any age with developmental disabilities. These waivers are:

- #0185.90.R2 for seniors, adults w/physical disabilities
- #0117.90.R3.01 for individuals with developmental disabilities (Comprehensive)
- #0375.01 Support services for adults with developmental disabilities
- #40193.90.02 Medically fragile children
- # 0565.R00 Medically Involved Children's Waiver
- #40194.90.02 Children with severe behavioral challenges.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

SPD staff re-evaluate the QIS at least once during each waiver renewal period (or more as deemed appropriate) and update the QIS strategies employed.

The aforementioned WO, WOW and DD-QAC meetings are scheduled, staffed and facilitated by Quality Assurance and waiver staff from the Office of Federal Resource and Financial Eligibility. These staff and Waiver program representatives bring forth issues, trends, priorities and concerns related to the QMS on both individual and multi-waiver levels. These groups evaluate and make recommendations to amend the QMS, OARs and policies as necessary to promote high quality services for waiver participants.

\*At a minimum annually CIIS staff formally report QA activities and trends to the Statewide Quality Assurance Committee.\*

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for

conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

SPD requires providers to maintain relevant service record information for a minimum of three years, per federal regulatory requirements. Service providers are required to permit authorized representatives of DHS to review these records for audit purposes. Providers are required to meet the requirements stated in OAR 411.351.0000 et seq.

Audit staff from the Department of Human Services and the Secretary of State's Office periodically review payment records of Department providers based on their applicable state statutes and administrative rules to ensure provider billing integrity. Staff from both agencies set audit priorities each year based upon assessed risk analysis. Audit methods include on-site review as well as independent data analysis.

DHS auditors periodically evaluate provider financial condition and contractual compliance, review fiscal audits performed on contractors by other agencies, provide consultation to the Secretary of State's Division of Audits programs, and evaluate provider financial system issues for compliance with federal and state standards. DHS determines the frequency of audits and also requests random records monthly. CIIS coordinators review all provider payments monthly. DHS and state auditors audit CIIS waiver payments on a regular (monthly) basis and select specific program areas for full audits based on pre-determined criteria and timeframes.

A government body, an organization or an individual can trigger an audit. DHS auditors perform both desk reviews and on-site examinations of providers' records, facilities and operations, and other information Internal Programs. DHS auditors provide timely, accurate, independent and objective information about DHS operations and programs. An internal audit committee made up of representatives from each DHS administrative unit, including SPD, works closely with the Audit Unit to ensure comprehensive audit coverage. The committee approves an annual audit plan of risk-based and required cyclical audits, then meets every two months, updating the plan as needed based on special requests, investigations, legislative inquiry, or other administrative direction. Auditors have complete access to all necessary activities, records, property and employees. The auditors have no direct authority over activities being reviewed. They abide by the Institute of Internal Auditors' Code of Ethics and practices conform to the Standards for the Professional Practice of Internal Auditing, as promulgated by the Institute of Internal Auditors, the American Institute of CPA's (AICPA), the Federal General Accounting Office (GAO) Yellow Book, Institute of Internal Auditors (IIA), and Information Systems Audit and Control Association (ISACA). DHS internal audits fall into two categories: classification and issue-specific.

Priority for audits is set by: Risk analysis, assessing the extent of fiscal, legal, and/or public policy impact for each potential audit subject, with those having the highest level of risk given top priority; and Database analysis, which determines the quantity, magnitude, degree of aberration, and inconsistencies that exist in current application of practices. Audit Unit staff and the audit committee use the audit process to assess functions and control systems and to make recommendations to DHS administration regarding issues such as: economical and efficient use of resources; progress meeting DHS goals and outcomes; reliability and integrity of information; consumer health and safety; compliance with laws, regulations, policies, procedures, and contract terms; safeguarding assets, adequacy of internal controls; sound fiscal practices; effective management systems; and security and controls of information systems.

Secretary of State Audits: The Audits Division is responsible for carrying out the duties of the Secretary of State's Office as the constitutional Auditor of Public Accounts. The Audits Division is the only independent auditing organization in the state with the authority to review programs of agencies in all three branches of state government and other organizations receiving state money. Authority for the responsibilities of the Audits Division is found in sections 297.00 through 297.990 of the Oregon Revised Statutes. Secretary of State auditors review the areas of finance, performance, information technology, and fraud and abuse. Frequency of SOS audits is based on risk assessment and on standards established by nationally-recognized entities including, but not limited to, the GAO and the National Association of State Auditors. Types of audits include: Financial and compliance audits of all components of state government and state-aided institutions. These audits determine whether a state agency has conducted its financial operations properly and has presented its financial statements in accordance with generally accepted accounting principles. Examinations of internal control structures and determine whether state agencies have complied with finance-related legal requirements. At the end of each engagement, the Division prepares an opinion regarding financial statements, reports significant finds, and recommends any necessary improvements.

Financial and compliance audits of the state's annual financial statements: This audit, the largest audit of public funds in the state and a major engagement of the Division, complies with the Single Audit Act of 1984 (PL 92-502) which requires such an audit annually as a condition of eligibility for Federal funds:

- Performance audits of the operations and results of state programs determine whether the programs are conducted in an economical and efficient manner;

- Special studies and investigations regarding misuse of state resources or inefficient management practices;
- Requested audits or special studies for counties.

In accordance with statutory provisions and in cooperation with the State Board of Accountancy and the Oregon Society of Certified Public Accountants, the Division: develops the standards for conducting audits of all Oregon municipal corporations; prescribes, revises, and maintains minimum standards for audit reports; and reviews reports, certificates, and procedures for audits and reviews of corporations. The Division evaluates reports of audits or reviews of these municipal corporations and auditor's work papers for compliance with the standards. In addition to audit activities of the DHS Audit Unit and Secretary of State Audit Division.

The DHS Office of Payment Accuracy and Recovery receives reports of fraud in DHS programs and investigates allegations. The Office maintains a hotline for anyone to report fraud and will investigate allegations against providers such as billing for services not rendered, intentionally billing in duplicate, billing for higher level of services than was delivered, billing for services provided by unlicensed or otherwise ineligible practitioners, and kickback schemes.

## Appendix I: Financial Accountability

### Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

#### a. Methods for Discovery: Financial Accountability

*State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*

##### i. Performance Measures

*For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.*

#### Performance Measure:

**The percentage of claims that are authorized and paid for in accordance with reimbursement specified in the approved waiver - Numerator: Reimbursements that are authorized and paid for in accordance with the methods specified in the approved waiver - Denominator: All reimbursements**

Data Source (Select one):

**Financial records (including expenditures)**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: *CIIS uses the Raosoft calculator to determine sample sizes. For this homogeneous population, staff use: 10% margin of error, 90% confidence limits, and a response distribution of 20%.*
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

CIIS reviews all vouchers before payment.

The Service Coordinator assures that all credit card purchases are authorized in the plan of care before making purchases.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The CIIS Manager reviews all purchases made and services authorized and approves or sends back to Service Coordinator for correction or further documentation.

As part of management review, purchases not authorized under the waiver, but consistent with the plan of care, are made with State general fund dollars.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No**  
 **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (1 of 3)

- a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rates are a combination of:

- Department of Medical Assistance rates for State plan services; and
- CIIS-determined rates based on local employment rates, availability of providers, skills of the provider, and type of provider.

\*The public is able to comment on rates either directly to the service coordinator, the CIIS manager, or other DHS employees.

CIIS uses the following methods to determine provider payment rates for the waiver services listed:

Family Training:

- Counseling- Rate ranges are determined based on employment and market rates for the type of provider and the provider is paid for the billing cost of their services.
- Conference - the actual cost of enrollment fees and educational materials.

Homemaker/Chore:

Payment rate derived directly from SPD rate schedule for Home Care Workers.

PT/OT/Speech and Language:

Payment will be based on the Division of Medical Assistance Program's (DMAP) fee schedule. The fee schedule is the same for both governmental and private providers. The Oregon fee schedule is published in the State Register by the Secretary of State.

Environmental Accessibility Adaptations:

A scope of work is created for the adaptation. From the scope of work, a minimum of three bids or estimates of the cost of the adaptation are received from qualified providers. The provider who submits the most cost-effective bid or estimate is chosen to complete the home adaptation.

Translation:

Rates are established by existing DHS contract for translation services through qualified vendors.

Specialized Diets:

Rates for Specialized Diets are the actual, most cost-effective price for the product offered through appropriate vendors.

Non-Medical Transportation:

Transportation rates are set using SPD's published transportation rates. When waiver recipients are sharing transportation the shared miles are prorated between the waiver recipients.

Behavioral Consultant:

Rate ranges are determined based on employment and market rates for the type of provider and the provider is paid for the billing cost of their services.

Respite:

Hourly: Locally-based rate, adjusted based on the complexity of the needs of the person served and locality.

- Daily: Locally-based rate, adjusted based on the complexity of the needs of the person served and locality.

Specialized Medical Equipment and Supplies:

- Capital Equipment Expenditures: When an individual's need for a piece of specialized medical equipment or supplies is identified, actual costs of the equipment or supplies are obtained from multiple qualified vendors. The equipment is purchased from the qualified vendor who offers the most cost-effective actual cost.
- Ongoing Equipment and Supplies: Actual purchase costs.\*

CIIS coordinators provide rate information to waiver participants verbally and in writing if requested.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers bill the state directly. There are no fiscal intermediaries.

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (2 of 3)

**c. Certifying Public Expenditures** *(select one):*

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

*Select at least one:*

**Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

**Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

\*CIIS reviews all claims and supporting documentation prior to making payment for a CIIS service. Prior to payment, regardless of the specific SPD payment system utilized, CIIS staff assure that claims are for a time period when the child was actively enrolled in the CIIS waiver and that the service was prior authorized in the plan of care. CIIS compares all claims or bills to the corresponding prior authorization to assure the type and amount of service match the authorization. Depending on the type of service or supply, CIIS verifies with the family that the service was provided by one or more of the following methods: a phone or e-mail conversation or visit to the home; review of time sheets signed by both the parent and provider; review of consultant report and invoice; review of nursing or direct care staff logs, etc. All payments are logged and tracked according to DHS and Department of Administrative Services accounting standards.\*

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

### I-3: Payment (1 of 7)

#### a. Method of payments -- MMIS (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

MMIS pays for the following services:

Occupational Therapy, Physical Therapy, Speech/Language Therapy, Family counseling provided by social workers and psychologists, and respite.

Waiver services currently not paid through MMIS are: behavior consultation, non-medical transportation, durable medical equipment and supplies, special diets, environmental adaptations, homemaker/chore, family training/education, and translation. These services are paid by credit card, checks, contracts, or purchase orders and reported through the Client Process Monitoring System (CPMS) or other systems. SPD bills Medicaid for these services through CPMS or other systems.

The audit trail is maintained in the payment systems, with supporting documentation maintained in the individual files and financial files.

Accounting staff use the information from paid claims to draw federal funds.

Non-MMIS providers can be paid directly from the Medicaid agency.

SPD and DHS staff write the checks or pay by credit card, depending upon the service rendered.

DHS and the Department of Administrative Services have developed very specific requirements for tracking and auditing for this purpose. \*CIIS is responsible for directly purchasing authorized services and equipment. CIIS does not reimburse or supply funds to families for purchases.\* All credit card payments are recorded on a log. The log and receipts are reconciled monthly with the credit card statements and reviewed by CIIS manager and are reviewed and documented by MFCU manager.

The Medicaid agency pays all providers directly. No Medicaid payment goes to or is paid to the parent/legal guardian or child.

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

### I-3: Payment (4 of 7)

**d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

## Appendix I: Financial Accountability

### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

**Answers provided in Appendix I-3-d indicate that you do not need to complete this section.**

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

## Appendix I: Financial Accountability

### I-3: Payment (6 of 7)

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

##### i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

##### ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

##### iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**  
 **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.  
 **Applicable**  
*Check each that applies:*

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**  
*Check each that applies:*
  - Health care-related taxes or fees**
  - Provider-related donations**
  - Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

**a.**

**Services Furnished in Residential Settings.** *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
  - As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**
- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

CIIS pays only for staff and camp activity fees.

CIIS does not pay the cost of room and board in any residential setting used for respite care.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a.

**Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

#### i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

#### ii. Participants Subject to Co-pay Charges for Waiver Services.

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability****I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration****J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

**Level(s) of Care: ICF/MR**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	1751.55	21722.51	23474.06	340680.00	3945.00	344625.00	321150.94
2	1811.30	22591.41	24402.71	354307.00	4103.00	358410.00	334007.29
3	1835.64	23495.07	25330.71	368479.00	4267.00	372746.00	347415.29
4	1872.28	24434.87	26307.15	383219.00	4438.00	387657.00	361349.85
5	1909.88	25412.27	27322.15	398547.00	4615.00	403162.00	375839.85

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/MR	
Year 1	143	143	
Year 2	150	150	
Year 3	160	160	
Year 4	160	160	
Year 5	160	160	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

338 Days -

Actual LOS from most recent 372 waiver report.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.
- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:
 

SPD based Factor D cost projections on actual expenditures incurred for delivery of waiver services to children under this waiver during the most recent waiver reporting year.
  - ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:
 

SPD based Factor D' cost projections on actual expenditures incurred for delivery of acute care services to children served under this waiver during the most recent waiver reporting year.  
SPD used expenditures drawn from services delivered after Part D Medicare was in effect. Thus, the data account for the removal of prescribed drugs from the estimate.
  - iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:
 

SPD based Factor G cost projections on actual expenditures incurred for delivery of ICF/MR services to similar children over a one-year period.

**iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SPD based Factor G' cost projections on actual expenditures incurred for delivery of acute care services to similar children served in ICFs/MR over a one-year period.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (4 of 9)**

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Homemaker/Chore	
Respite	
Physical Therapy/Occupational Therapy/Speech and Language	
Behavioral Consultant	
Environmental Accessibility Adaptations	
Family Training	
Non-Medical Transportation	
Special Diets	
Specialized Medical Equipment and Supplies	
Translation	

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (5 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 1**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Homemaker/Chore Total:</b>							51765.00
Homemaker/Chore	<input type="checkbox"/>	Hours	35	145.00	10.20	51765.00	
<b>Respite Total:</b>							20000.00
Respite Hourly	<input type="checkbox"/>	Hours	10	16.00	12.50	2000.00	
Respite Daily	<input type="checkbox"/>	Days	10	12.00	150.00	18000.00	
<b>Physical Therapy/Occupational</b>							12751.20
<b>GRAND TOTAL:</b>							250472.20
Total Estimated Unduplicated Participants:							143
Factor D (Divide total by number of participants):							1751.55
Average Length of Stay on the Waiver:							338

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Therapy/Speech and Language Total:</b>							
Occupational Therapy	<input type="checkbox"/>	Hours	10	8.00	82.80	6624.00	
Physical Therapy	<input type="checkbox"/>	Hours	3	6.00	82.80	1490.40	
Speech Therapy	<input type="checkbox"/>	Hours	7	8.00	82.80	4636.80	
<b>Behavioral Consultant Total:</b>							24750.00
Behavioral Consultant	<input type="checkbox"/>	Hours	22	15.00	75.00	24750.00	
<b>Environmental Accessibility Adaptations Total:</b>							42000.00
Environmental Accessibility Adaptations	<input type="checkbox"/>	One Modification	35	1.00	1200.00	42000.00	
<b>Family Training Total:</b>							3400.00
Education	<input type="checkbox"/>	Event	5	2.00	100.00	1000.00	
Counseling	<input type="checkbox"/>	Hour	8	4.00	75.00	2400.00	
<b>Non-Medical Transportation Total:</b>							7137.00
Non-Medical Transportation	<input type="checkbox"/>	Rides	15	10.00	47.58	7137.00	
<b>Special Diets Total:</b>							3600.00
Special Diets	<input type="checkbox"/>	Purchase Costs	6	12.00	50.00	3600.00	
<b>Specialized Medical Equipment and Supplies Total:</b>							81554.00
Ongoing Equipment and Supplies	<input type="checkbox"/>	Purchase Costs	85	12.00	67.70	69054.00	
Capitol Equipment Expenditures	<input type="checkbox"/>	Event	5	1.00	2500.00	12500.00	
<b>Translation Total:</b>							3515.00
Translation	<input type="checkbox"/>	Hours	5	20.00	35.15	3515.00	
<b>GRAND TOTAL:</b>							250472.20
Total Estimated Unduplicated Participants:							143
Factor D (Divide total by number of participants):							1751.55
Average Length of Stay on the Waiver:							338

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 2**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Homemaker/Chore Total:</b>							55796.00
Homemaker/Chore	<input type="checkbox"/>	Hours	37	145.00	10.40	55796.00	
<b>Respite Total:</b>							22440.00
Respite Hourly	<input type="checkbox"/>	Hours	11	16.00	12.75	2244.00	
Respite Daily	<input type="checkbox"/>	Days	11	12.00	153.00	20196.00	
<b>Physical Therapy/Occupational Therapy/Speech and Language Total:</b>							13682.52
Occupational Therapy	<input type="checkbox"/>	Hours	11	8.00	84.46	7432.48	
Physical Therapy	<input type="checkbox"/>	Hours	3	6.00	84.46	1520.28	
Speech Therapy	<input type="checkbox"/>	Hours	7	8.00	84.46	4729.76	
<b>Behavioral Consultant Total:</b>							27540.00
Behavioral Consultant	<input type="checkbox"/>	Hours	24	15.00	76.50	27540.00	
<b>Environmental Accessibility Adaptations Total:</b>							45288.00
Environmental Accessibility Adaptations	<input type="checkbox"/>	One Modification	37	1.00	1224.00	45288.00	
<b>Family Training Total:</b>							3774.00
Education	<input type="checkbox"/>	Event	5	2.00	102.00	1020.00	
Counseling	<input type="checkbox"/>	Hour	9	4.00	76.50	2754.00	
<b>Non-Medical Transportation Total:</b>							7764.80
Non-Medical Transportation	<input type="checkbox"/>	Rides	16	10.00	48.53	7764.80	
<b>Special Diets Total:</b>							3672.00
Special Diets	<input type="checkbox"/>	Purchase Costs	6	12.00	51.00	3672.00	
<b>Specialized Medical Equipment and Supplies Total:</b>							88152.60
Ongoing Equipment and Supplies	<input type="checkbox"/>	Purchase Costs	91	12.00	69.05	75402.60	
Capitol Equipment Expenditures	<input type="checkbox"/>	Event	5	1.00	2550.00	12750.00	
<b>Translation Total:</b>							3585.00
Translation	<input type="checkbox"/>	Hours	5	20.00	35.85	3585.00	
<b>GRAND TOTAL:</b>							271694.92
Total Estimated Unduplicated Participants:							150
Factor D (Divide total by number of participants):							1811.30
Average Length of Stay on the Waiver:							338

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (7 of 9)**

**d. Estimate of Factor D.**

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Homemaker/Chore Total:</b>							59999.55
Homemaker/Chore	<input type="checkbox"/>	Hours	39	145.00	10.61	59999.55	
<b>Respite Total:</b>							24970.56
Respite Hourly	<input type="checkbox"/>	Hours	12	16.00	13.01	2497.92	
Respite Daily	<input type="checkbox"/>	Days	12	12.00	156.06	22472.64	
<b>Physical Therapy/Occupational Therapy/Speech and Language Total:</b>							14645.50
Occupational Therapy	<input type="checkbox"/>	Hours	12	8.00	86.15	8270.40	
Physical Therapy	<input type="checkbox"/>	Hours	3	6.00	86.15	1550.70	
Speech Therapy	<input type="checkbox"/>	Hours	7	8.00	86.15	4824.40	
<b>Behavioral Consultant Total:</b>							30431.70
Behavioral Consultant	<input type="checkbox"/>	Hours	26	15.00	78.03	30431.70	
<b>Environmental Accessibility Adaptations Total:</b>							48690.72
Environmental Accessibility Adaptations	<input type="checkbox"/>	One Modification	39	1.00	1248.48	48690.72	
<b>Family Training Total:</b>							4161.60
Education	<input type="checkbox"/>	Event	5	2.00	104.04	1040.40	
Counseling	<input type="checkbox"/>	Hour	10	4.00	78.03	3121.20	
<b>Non-Medical Transportation Total:</b>							8415.00
Non-Medical Transportation	<input type="checkbox"/>	Rides	17	10.00	49.50	8415.00	
<b>Special Diets Total:</b>							3745.44
Special Diets	<input type="checkbox"/>	Purchase Costs	6	12.00	52.02	3745.44	
<b>Specialized Medical Equipment and Supplies Total:</b>							94985.52
Ongoing Equipment and Supplies	<input type="checkbox"/>	Purchase Costs	97	12.00	70.43	81980.52	
Capitol Equipment Expenditures	<input type="checkbox"/>	Event	5	1.00	2601.00	13005.00	
<b>Translation Total:</b>							3657.00
Translation	<input type="checkbox"/>	Hours	5	20.00	36.57	3657.00	
<b>GRAND TOTAL:</b>							293702.59
Total Estimated Unduplicated Participants:							160
Factor D (Divide total by number of participants):							1835.64
Average Length of Stay on the Waiver:							338

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Homemaker/Chore Total:</b>							61187.10
Homemaker/Chore	<input type="checkbox"/>	Hours	39	145.00	10.82	61187.10	
<b>Respite Total:</b>							25469.76
Respite Hourly	<input type="checkbox"/>	Hours	12	16.00	13.27	2547.84	
Respite Daily	<input type="checkbox"/>	Days	12	12.00	159.18	22921.92	
<b>Physical Therapy/Occupational Therapy/Speech and Language Total:</b>							14937.90
Occupational Therapy	<input type="checkbox"/>	Hours	12	8.00	87.87	8435.52	
Physical Therapy	<input type="checkbox"/>	Hours	3	6.00	87.87	1581.66	
Speech Therapy	<input type="checkbox"/>	Hours	7	8.00	87.87	4920.72	
<b>Behavioral Consultant Total:</b>							31040.10
Behavioral Consultant	<input type="checkbox"/>	Hours	26	15.00	79.59	31040.10	
<b>Environmental Accessibility Adaptations Total:</b>							49664.55
Environmental Accessibility Adaptations	<input type="checkbox"/>	One Modification	39	1.00	1273.45	49664.55	
<b>Family Training Total:</b>							4244.80
Education	<input type="checkbox"/>	Event	5	2.00	106.12	1061.20	
Counseling	<input type="checkbox"/>	Hour	10	4.00	79.59	3183.60	
<b>Non-Medical Transportation Total:</b>							8583.30
Non-Medical Transportation	<input type="checkbox"/>	Rides	17	10.00	50.49	8583.30	
<b>Special Diets Total:</b>							3820.32
Special Diets	<input type="checkbox"/>	Purchase Costs	6	12.00	53.06	3820.32	
<b>Specialized Medical Equipment and Supplies Total:</b>							96886.86
<b>GRAND TOTAL:</b>							299564.69
Total Estimated Unduplicated Participants:							160
Factor D (Divide total by number of participants):							1872.28
Average Length of Stay on the Waiver:							338

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Ongoing Equipment and Supplies	<input type="checkbox"/>	Purchase Costs	97	12.00	71.84	83621.76	
Capitol Equipment Expenditures	<input type="checkbox"/>	Event	5	1.00	2653.02	13265.10	
<b>Translation Total:</b>							3730.00
Translation	<input type="checkbox"/>	Hours	5	20.00	37.30	3730.00	
<b>GRAND TOTAL:</b>							299564.69
Total Estimated Unduplicated Participants:							160
Factor D (Divide total by number of participants):							1872.28
Average Length of Stay on the Waiver:							338

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

**i. Non-Concurrent Waiver.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Homemaker/Chore Total:</b>							62431.20
Homemaker/Chore	<input type="checkbox"/>	Hjourns	39	145.00	11.04	62431.20	
<b>Respite Total:</b>							25979.52
Respite Hourly	<input type="checkbox"/>	Hours	12	16.00	13.54	2599.68	
Respite Daily	<input type="checkbox"/>	Days	12	12.00	162.36	23379.84	
<b>Physical Therapy/Occupational Therapy/Speech and Language Total:</b>							15237.10
Occupational Therapy	<input type="checkbox"/>	Hours	12	8.00	89.63	8604.48	
Physical Therapy	<input type="checkbox"/>	Hours	3	6.00	89.63	1613.34	
Speech Therapy	<input type="checkbox"/>	Hours	7	8.00	89.63	5019.28	
<b>Behavioral Consultant Total:</b>							31660.20
Behavioral Consultant	<input type="checkbox"/>	Hours	26	15.00	81.18	31660.20	
<b>Environmental Accessibility Adaptations Total:</b>							50657.88
Environmental Accessibility Adaptations	<input type="checkbox"/>	One Modification	39	1.00	1298.92	50657.88	
<b>GRAND TOTAL:</b>							305580.46
Total Estimated Unduplicated Participants:							160
Factor D (Divide total by number of participants):							1909.88
Average Length of Stay on the Waiver:							338

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Family Training Total:</b>							4329.60
Education	<input type="checkbox"/>	Event	5	2.00	108.24	1082.40	
Counseling	<input type="checkbox"/>	Hour	10	4.00	81.18	3247.20	
<b>Non-Medical Transportation Total:</b>							8755.00
Non-Medical Transportation	<input type="checkbox"/>	Rides	17	10.00	51.50	8755.00	
<b>Special Diets Total:</b>							3896.64
Special Diets	<input type="checkbox"/>	Purchase Costs	6	12.00	54.12	3896.64	
<b>Specialized Medical Equipment and Supplies Total:</b>							98828.32
Ongoing Equipment and Supplies	<input type="checkbox"/>	Purchase Costs	97	12.00	73.28	85297.92	
Capitol Equipment Expenditures	<input type="checkbox"/>	Event	5	1.00	2706.08	13530.40	
<b>Translation Total:</b>							3805.00
Translation	<input type="checkbox"/>	Hours	5	20.00	38.05	3805.00	
<b>GRAND TOTAL:</b>							305580.46
Total Estimated Unduplicated Participants:							160
Factor D (Divide total by number of participants):							1909.88
Average Length of Stay on the Waiver:							338